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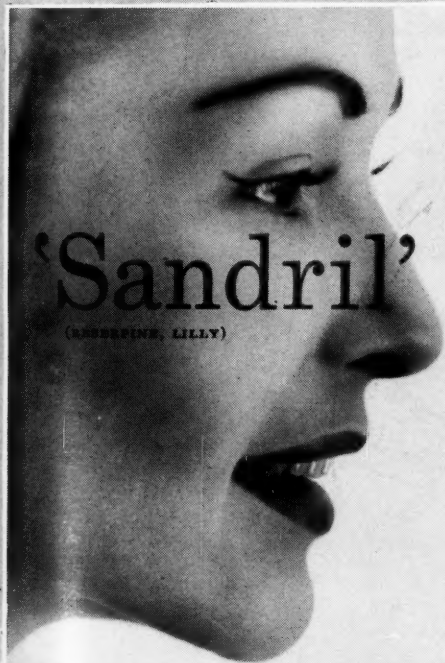
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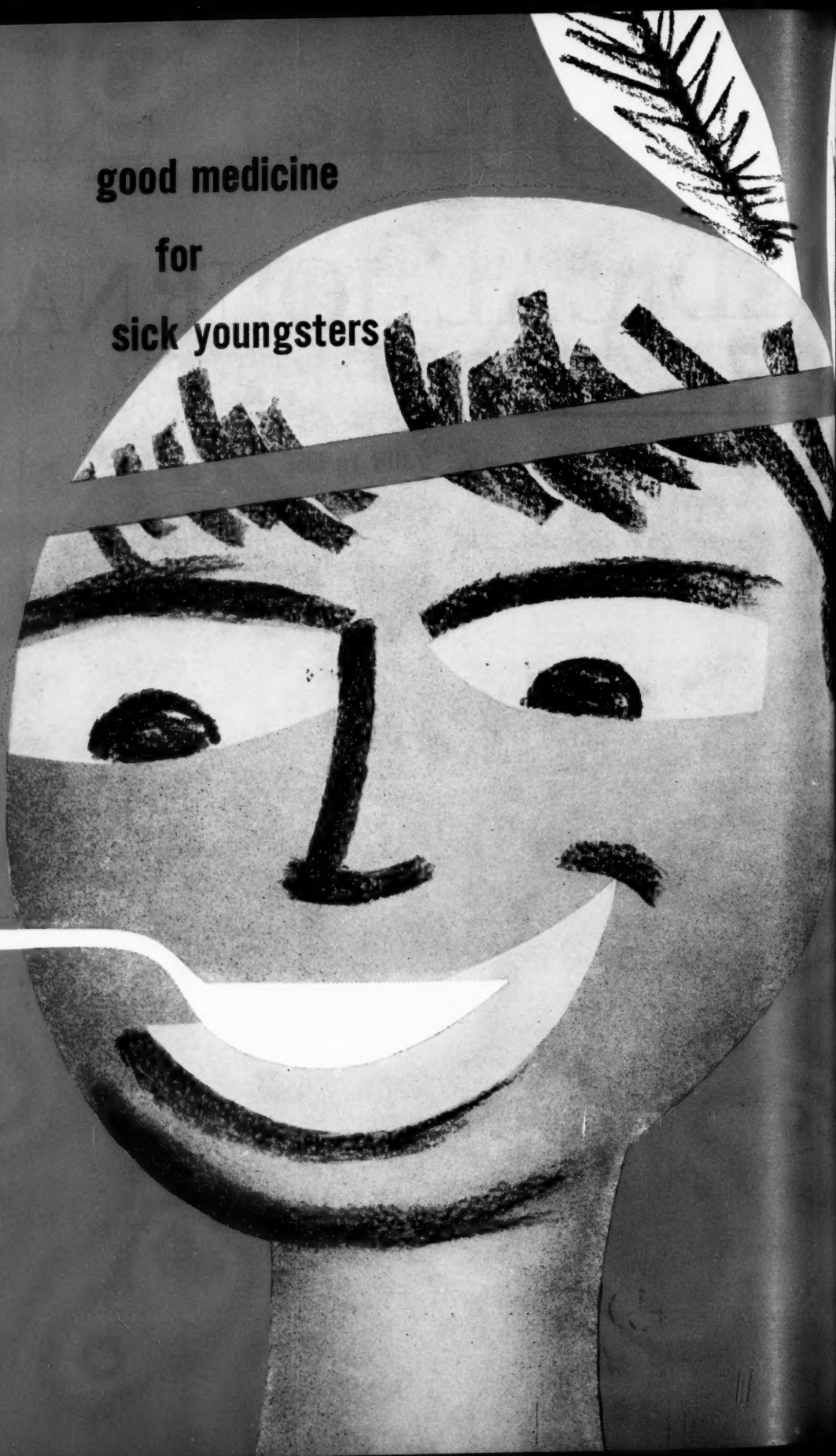
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VOLUME XXXIX, NO. 5

TABLE OF CONTENTS, PAGE 241

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Volume XXXIX, No. 5

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TABLE OF CONTENTS

| | PAGE |
|--|------|
| INTRACRANIAL SURGERY FOR HEMIPLEGIA AND CONVULSIONS, <i>Maurice L. Silver, M.D.</i> | 251 |
| CINEPLASTIC SURGERY, A Case Report, <i>A. A. Savastano, M.D.</i> | 257 |
| MASSIVE HEMORRHAGE FROM PEPTIC ULCER, <i>Warren W. Francis, M.D.</i> and <i>Paul T. Welch, M.D.</i> | 260 |

EDITORIALS

| | |
|--|-----|
| Peter Pineo Chase | 265 |
| Doctor Danforth Medical Scholarships | 266 |
| Far From Routine | 287 |

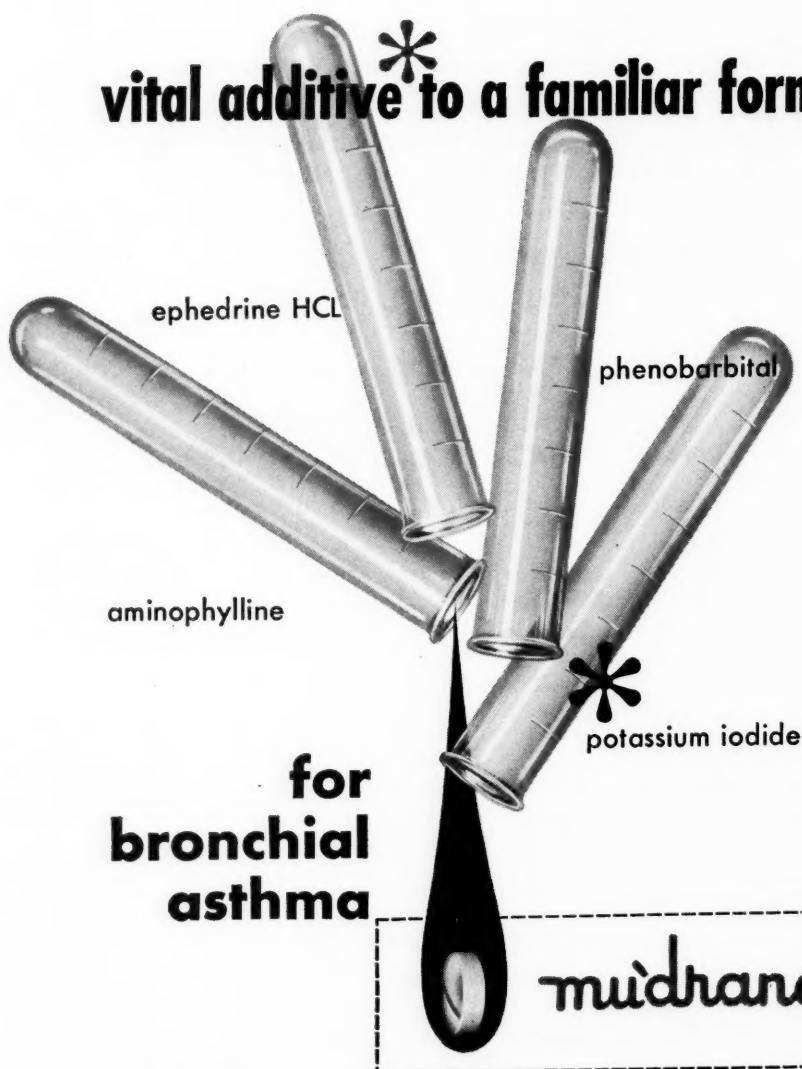
DEPARTMENTS

| | |
|---|-----|
| President's Message | 269 |
| Officers Installed for 1956-57 | 270 |
| Officers and Standing Committees, Rhode Island Medical Society, 1956-57 | 274 |
| District Medical Society Meetings | 278 |
| On the Medical Library Bookshelves | 284 |
| Book Reviews | 288 |

MISCELLANEOUS

| | |
|--|-------------|
| Citations in Memory of Doctor Peter Pineo Chase: | |
| Rhode Island General Assembly | 276 |
| Connecticut State Medical Society | 277 |
| General Practice Chapter Elects | 263 |
| Rhode Island Doctors Cited | 263 |
| Photographs: | |
| Charles L. Farrell, M.D. | 268 |
| Officers of R. I. Medical Society | 272 and 275 |
| R. Thomas Stevens, M.D. | 278 |
| Index of Advertisers | 291 |

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INTRACRANIAL SURGERY FOR HEMIPLEGIA AND CONVULSIONS

MAURICE L. SILVER, M.D.

The Author. *Maurice L. Silver, M.D., of Providence, Rhode Island. Chief, Department of Neurological Surgery, Miriam Hospital; Visiting Neurosurgeon, St. Joseph's, Our Lady of Fatima, Roger Williams General and Newport hospitals, and at Emma Pendleton Bradley Home.*

Introduction

UNTIL ten years ago, cases of brain damage in children were regarded generally as being beyond hope of improvement. Children with neuromuscular disability or convulsions beginning at birth or manifest during infancy, tended to receive the most guarded prognosis possible. The known incapacity for regeneration of central nervous tissue appeared to preclude any hope of recovery. Physiotherapy directed against severe contractures, or the use of braces to attempt to maintain a more favorable position of the extremities, was the dominant therapeutic approach. When convulsions occurred in these already handicapped children, they tended to dominate the clinical picture. Often, the over-all medical care of the patient was divided between anticonvulsant medication under neurological supervision, and orthopedic management of weakened or paralyzed extremities.

In these cases, during development from childhood to adolescence, clinical progress usually diminished. In fact, many patients were worse despite treatment; the hemiparesis and spasticity were more disabling (despite braces and physiotherapy) and the seizures were more frequent (despite higher doses of anticonvulsant medication).

This confirmed the gloomy predictions of pessimistic physicians and neurophysiologists, based upon theoretical consideration of the advanced neuropathological changes within the brain.

However, recent detailed investigations in the field of cerebral palsy, and careful physiologic studies at neurosurgical centers, have indicated that in certain favorable situations a dramatic reversal may be effected in the downhill course of patients with hemiplegia and convulsions. The

experience of Penfield and his co-workers at the Montreal Neurological Institute, and Walker and his co-workers at the Johns Hopkins Hospital, have shown that successful surgery for intractable seizures can be accomplished. This depends largely upon the surgeon's ability to localize the cerebral epileptogenic focus by electrical recording from the brain during surgery.

Following surgical excision of the irritable cortex apparently responsible for the epileptogenic discharge there was not only relief of convulsive seizures, but in addition, decrease in spasticity and increase in power in the paralyzed extremities. It appeared that the spastic hemiparesis was not merely the result of local damage to cerebral neurones, but rather that the progressive weakness, incoordination and spasticity was the result of continuous abnormal electrical activity in the cerebral cortex, cessation of which permits improved function and improved capacity for muscle re-education.

During the course of a combined research program between the Meeting Street School and the Miriam Hospital, a classification of cerebral palsy cases based upon pneumoencephalographic findings was established. Based upon this classification, it has become possible to select cases which have a favorable prognosis under neurosurgical treatment. Two local cases have been selected for presentation, and are described in detail, because they illustrate the favorable results that can be expected in selected cases of hemiplegia with convulsions.

Case History #1: J.J., a fourteen-year-old female, was referred in neurosurgical consultation because of convulsions, uncontrolled by medication during the past year, and a left spastic hemiparesis dating to infancy.

The patient was born on December 9, 1938 at the Newport Hospital, a premature infant weighing four pounds. The record indicates that the mother was considered to have a mild toxemia of pregnancy. A few years later, the mother noted a lump in her breast which was excised and immediately following this, she was submitted to right radical mastectomy on January 23, 1943. The pathological

continued on next page

report was: typical scirrhous carcinoma, with metastases to axillary lymph nodes. Later in the year, the mother was re-admitted with pain in the shoulder and abdomen and she expired from multiple metastases on November 1, 1943. The patient's father since remarried and the child was brought up by her father and stepmother, who are very devoted to her.

At age two, the patient was brought to the Out-Patient Department because of progressive left hemiplegia considered to be due to cerebral palsy or possibly poliomyelitis. She was treated by physiotherapy and in the period from August 1945 to June 1946, she was fitted with braces. Despite a spastic left hemiparesis, the child attended school and reached the seventh grade along with other children of the same age.

In 1952, just after the onset of menarche, she had a generalized seizure which began with a feeling of numbness in the left arm, spreading to involve the entire left side of the body, and then ending as a generalized convulsion. She was treated by her local physician with phenobarbital and dilantin but the attacks persisted. She was referred in neurosurgical consultation on January 20, 1953.

At this time, she presented a typical spastic deformity most marked in the left upper extremity, but also present as an equino-varus deformity of the left foot corrected by a built-up shoe. She walked with a pronounced limp.

Strength and motility in the left upper extremity were markedly impaired and the patient hardly used this extremity in any routine activity. She was unable to hold objects in it and unable to button her clothes or use her fingers in any type of skilled movement. She had developed the habit of concealing this extremity in all situations, tending to keep the hand in her pocket, and while standing or sitting, turning so as to face her right side toward the examiner.

Electroencephalography was performed and reported as follows:

Interpretation: This is a highly abnormal record with a focal disturbance of the cerebral rhythm in the right central region. This type of localized, high voltage spike activity is consistent with the presence of a cortical scar of the right cerebral hemisphere.

The clinical signs of spasticity of the left arm and left leg and the recent onset of grand mal convulsions would suggest that the patient has considerable atrophy of the right cerebral hemisphere, with an irritable focus in the right central area.

Diagnosis: Focal cerebral dysrhythmia, right central region, consistent with focal epilepsy.

The patient was advised admission to the hospital for combined pneumoencephalographic and

angiographic studies. The routine examination of the skull revealed an asymmetry with an apparent bowing and thinning of the right parietal bone. Air studies showed a tremendous accumulation of air in the region of the right cerebral hemisphere. The left lateral ventricle was filled, slightly dilated and displaced to the left of the midline. The third ventricle was filled and appeared to be tilted towards the left. Right cerebral angiography confirmed the fact that there was a marked hydrocephalus of the entire right lateral ventricle, best described as a porencephaly of the ventricle. The cerebral cortex overlying it was extremely thin and attenuated.

Surgical excision of the epileptogenic area of the right cerebral hemisphere was proposed and discussed at length with the family and the referring physician.

Surgery was carried out on February 4, 1953. Right parietal craniotomy was performed and study of the cortex was made by electrical stimulation and electrical recording. The cerebral cortex present immediately beneath the dura was relatively avascular and was without evidence of convolitional markings. Electrical stimulation in the right parietal area produced no discernible motor response from the left arm or the left side of the face. At the point of maximal spiking on the EEG, a large square of cortex approximately two by two

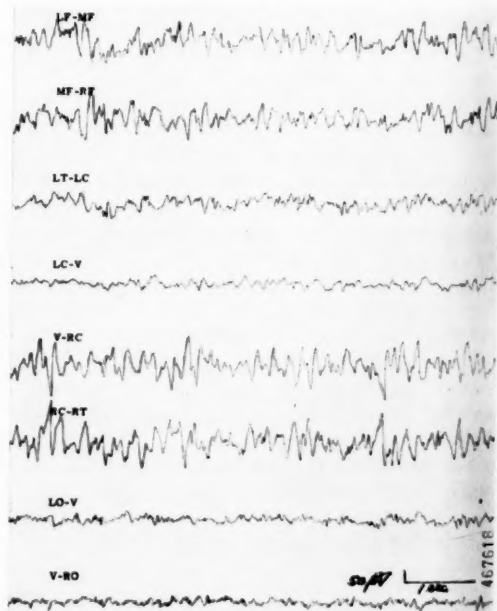


FIGURE 1

Electroencephalogram (Case No. 1) showing spike wave discharges from right central cortex. Notice reversal of sharp waves between paired leads (vertex-right central and right central-right temporal) indicating localization to common lead (right central).

inches was removed, producing a window into a huge porencephalic cyst. The interior of the cavity presented a smooth lining and no evidence of choroid plexus or the interventricular foramen of Monro could be made out. The cortex appeared to regain its normal thickness in the temporal region, but in the frontal and occipital areas, the cortex appeared to be paper-thin. The porencephalic cyst cavity was drained into the subarachnoid space by the cortical resection and the usual closure of the dura and the bone flap was performed. The patient made an uneventful recovery from surgery and was discharged from the Miriam Hospital on February 14, 1953.

The pathological report of the tissue removed was as follows: "One surface of the brain tissue is quite irregular and is covered by small vascular channels of capillary and arteriolar dimensions. The opposite surface is fairly smooth and is formed by condensed or compressed brain tissue, largely gliogenous. This is suggested by the longitudinally disposed nuclei which are flattened or at least oriented in a plane parallel with the brain surface and which are more compactly arranged. The intervening brain tissue is liberally sprinkled with glial cells. The neuronal cells show homogenation and basophilia of their nuclei, and to a lesser extent their cytoplasm. No ependyma is present in the section.

"Diagnosis: Brain tissue showing evidence of compression and degeneration."

Three weeks postoperatively, the patient showed

marked improvement in the strength of her left upper extremity. Her mother advised us that she was able to use it to hold a book while reading and in eating (which she could not do prior to her operation).

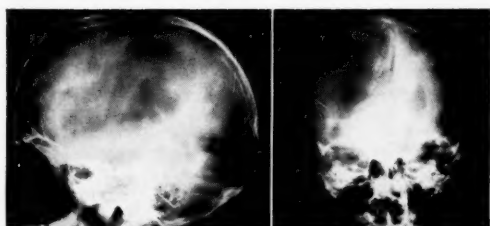
Following operation, she was returned to phenobarbital and dilantin medication at lower doses than she was taking preoperatively. She had a single seizure following surgery, on April 29, 1953, after she had neglected to take her anticonvulsant medication for a few days. This seizure occurred immediately prior to a menstrual period. Since that time, she has remained on regular doses of dilantin and phenobarbital which were decreased at six-month intervals, which medication was finally discontinued in 1955, two years after surgery. At this time, she walked well without trace of a limp, and was using her left upper extremity with great facility, although residuals of the long standing spastic hemiparesis were present. She has attended the Meeting Street School for therapeutic exercises and follow-up evaluation studies. She has done exceptionally well in her studies and was valedictorian of her junior high school graduating class. It is now more than three years following surgery and she is considered to be an attractive, well-adjusted adolescent girl, with no clinical evidence of a convulsive disorder and with only minimal neuromotor residuals of a former spastic hemiplegia.

Case History #2: J.B., a twenty-seven-year-old female was referred in neurosurgical consultation because of convulsions, dating to age twelve, and a spastic left hemiplegia resulting from an alleged "polio" at two years of age.

This patient was born on July 4, 1928 at a maternity home in East Greenwich, Rhode Island. It is noted that she was born by "instrument delivery," but no details are available. It is recalled by her parents that she could not sit up well and possibly had a "bad back." At age one and one-half years, there was noted difficulty in using the left upper and left lower extremities, and a diagnosis of poliomyelitis was made.

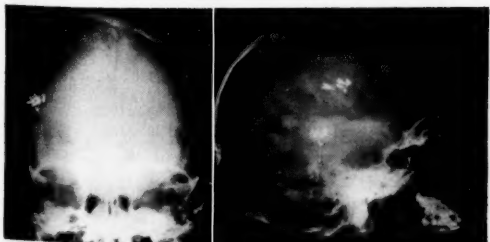
She was seen at the orthopedic clinic of the Rhode Island Hospital on June 30, 1932 because of turning-in of the left ankle and a tendency to fall. The patient walked with a left spastic gait, internal rotation of the left foot and the left arm was held flexed at the left elbow with poor flexion of the fingers of the left hand. The left limbs were noted to be smaller than the right and she was referred to the neurological clinic and then back to the orthopedic clinic. The parents were advised to continue manipulations of the left extremities and to educate the child in proper walking. By October of 1932, plans were initiated for the use of a brace for the left foot.

continued on next page



FIGURES 2a, 2b

(Case No. 1) (a) Lateral view, pneumoencephalogram, showing tremendous dilatation (porencephaly) of right lateral ventricle. (b) AP view.



FIGURES 3a, 3b

Postoperative X rays of the skull showing location of bone flap and area of cortical excision indicated by silver clips.

(a) AP view. (b) Lateral view.

She was referred to the Shriners' Hospital for Crippled Children in Springfield, Massachusetts, on October 19, 1933. At this time, her condition was diagnosed as "cerebral birth palsy of spastic left hemiplegic type." She was subsequently admitted there in December of 1934, for a period of intensive physiotherapy until February of 1935. At that time, there was relatively little improvement in her mild left equino-varus. However, she was noted to have severe convulsions. She was last treated there in November of 1937.

She apparently made fair progress in school until frequent seizures began at age twelve. The patient recalls that they were most apt to occur about the time of her menstrual periods. She was married, then developed appendicitis in 1946 and was submitted to surgery. In 1947 she was admitted with symptoms of a partial bowel obstruction and an exploratory laparotomy was performed in October of 1947, at which time a bilateral salpingectomy and right oophorectomy were carried out. On May 7, 1948, apparently because of vaginal bleeding, she underwent a panhysterectomy with the removal of the left ovary. In April of 1951, she underwent excision of a pilonidal sinus.

At this time, she suffered from hot flashes and other symptoms of surgical menopause, and her seizures became increasingly severe.

She received increasing doses of anticonvulsant medication from her attending neurologist and an

electroencephalogram performed on October 18, 1952, was reported as follows:

Classification:

A. Abnormal

- B. 1. (?) Paroxysmal, 3/second spike-wave complexes, generalized but with a right temporo-occipital predominance.
2. Moderately slow (S1) generalized but with a right temporo-occipital predominance. Hyperventilation — moderate build-up.



FIGURE 5

Preoperative electroencephalogram showing spike focus, right central area. This is a so-called monopolar recording, with frontal, temporal, central and occipital leads paired to the ear leads.

Interpretation: This is definitely an abnormal record. It has generalized slow activity which is clearly present and recurrent suggestive paroxysmal spike-wave complexes, which, however, are not clear enough for definite diagnosis. While both of these types of abnormality are generalized, they definitely are most marked in the right temporo-occipital regions.

This is consistent with the onset of idiopathic convulsive disorder, but because of the patient's relatively late age for onset and the suggestion of focal predominance, she should probably be studied very carefully to make sure that there is no local lesion serving as a precipitant for the recent appearance of convulsive disorder.

Increasing doses of medication were given, but without effect upon her seizures. Her referral in neurosurgical consultation was apparently precipitated by a seizure which occurred while she was a



FIGURES 4a, 4b

Photographs of Case No. 2, (a) one and one-half years, (b) twelve years, showing atrophy of left upper extremity, compared with right, considered to be due to poliomyelitis.

passenger in her husband's outboard motorboat. She fell overboard and almost drowned. Since that time she has been having at least two spells every day, and she was referred for neurosurgical opinion on August 19, 1955.

Examination disclosed a left spastic hemiplegia involving leg, arm and face. There was present a marked limp and complete inability to use the left arm in any coordinated movement.

Electroencephalography was reported as follows:

Interpretation: This is an abnormal electroencephalogram with focal spike discharge of considerable magnitude noted in the right central area. This appeared to be more prominent in the right parieto-occipital region than in the right fronto-parietal region.

EEG Diagnosis: Focal spike discharge, right parieto-occipital, consistent with convulsive disorder.

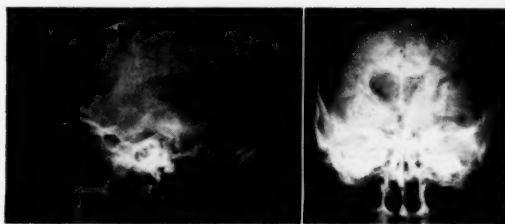
Admission to the hospital was advised for the performance of pneumoencephalography and cerebral angiography. These studies showed a large porencephalic dilatation of the posterior portion of the right lateral ventricle. A moderate amount of air was noted over the right hemisphere with suggestive evidence of traction scar between the dome of the porencephalic cyst and the subarachnoid space.

After discussing her case with her husband and the referring physician, she was admitted to the hospital for craniotomy on September 1, 1955 as follows:

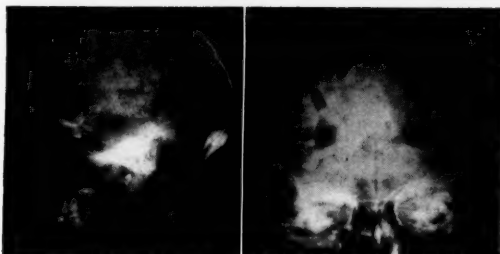
"This twenty-seven-year-old girl has intractable seizures, pneumoencephalographic findings of a porencephaly of the right lateral ventricle, and a spike focus on the electroencephalogram in the right central occipital area. Craniotomy is proposed for exposure of the pathologic lesion, electrocorticography, and resection of the epileptogenic focus.

"With the patient in the left lateral position and the head suitably prepared and draped, a horseshoe shaped incision was made beginning at the zygoma and extending in a curvilinear fashion towards the midline at the skull and curving backwards to the occipital region and ending at the mastoid bone. The scalp flap was caught with Raney clamps and the scalp edges with Dandy clamps. A large bone flap was outlined and trephine openings made using the Light-Veley automatic drill. These trephine openings were connected with Gigli saw cuts and a bone flap turned back using the temporalis muscle as a hinge.

"The dura was rather relaxed because of the previous pneumoencephalogram and existing presence of air within the ventricular system and in the subarachnoid space. There was no difficulty in reflecting the bone flap.



FIGURES 6a, 6b



FIGURES 6c, 6d

(Case No. 2) Pneumoencephalogram showing porencephalic dilatation of right lateral ventricle.

(a) AP view. (b) Lateral view. (c) Occiput-up lateral view. (d) PA view.

"A dural flap was then outlined with its base towards the sagittal sinus and of roughly the same area as the bone flap. This was turned back exposing the underlying cortex. In the anterior region corresponding to the right central area, the cortex appeared to be entirely normal. There was a normal vascular pattern and the gyri were of normal size. In the parieto-occipital region, in contrast, the gyri appear to be much smaller with larger pools of subarachnoid fluid and air, and a grayish-yellow almost gelatinous appearance of the cortex itself.

"The electrode holder was then clamped to the occipital region of the skull and the electrodes touched down in a regular pattern over the area of apparent gross pathology. Electrocorticography was carried out without technical artifact. There was a persistent area of spiking just posterior and superior to the area of microgyria with overlying edematous cortex. The area was scanned on three successive runs, and persistent activity was confined to a single setting in the center of this area. The electro-cautery was then used to coagulate the line of proposed cortical excision. A large block approximately six centimeters on edge was thus coagulated and then excised using subpial dissection. A ventricular needle was used to estimate the depth of the cortex and this was found to be between two and two and one-half centimeters immediately beneath the area of gross superficial scarring. A wedge was carried down to the ependymal lining of the ventricle and clear cerebrospinal fluid emerged. A permanent communication was established between the ventricle and the subarachnoid space

continued on next page

through the resected area of scarred cortex. With this opening into the ventricle, the cortex over the dilated ventricle collapsed and fell away from the dura.

"Following the resection, electrocorticography was again repeated with flat potentials recorded from the zone of cortical white matter that was exposed, and no spiking could be obtained from the adjacent gray matter.

"Routine closure was then performed. A few silver clips were required along the margins of the cortical excision but hemostasis was effected largely by coagulation and blunt dissection. The dura was closed in routine fashion and tacked up along its superior margin through the trephine openings. The galea and subcutaneous tissues were closed in the usual manner with interrupted sutures of fine black silk as was the scalp.

"The patient tolerated the operative procedure well and was returned to the ward in good condition."

The pathological specimen removed was described as follows: "Sections of brain tissue show fresh hemorrhage and some polys and fibrin in the meninges. This reaction is apparently secondary to operative trauma. In the gray matter, there is abundant glial cell infiltration. The adjacent cortex in its lower ganglion layers has a disorganized architecture because of gliosis. Ganglionic cells show ischemic cell changes. In some of the brain sections, a wall of a cavity lined by brain tissue is seen. Glial cells and fibrils adjacent to the cavity and capillaries and cells in the lower ganglionic layers of the cortex run parallel to the smooth luminal surface. Areas of gray matter in the vicinity of the cavity show rarefaction and vacuolization.

Diagnosis: Wall of porencephalic cyst.

Gliosis of gray and white matter of parietal lobe tissue.



FIGURE 7

Postoperative X ray, showing position of bone flap and area of cortical excision marked by silver clips.

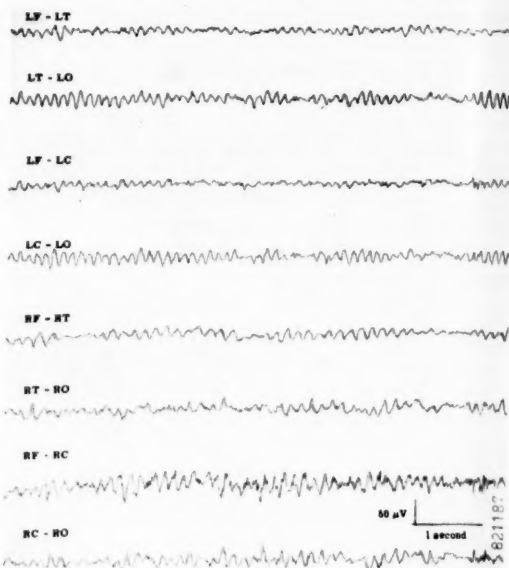


FIGURE 8

Postoperative electroencephalogram showing absence of spikes from right cerebral hemisphere leads.

The patient made an uneventful recovery from surgery and was discharged on September 6, 1955.

She was maintained on lower doses of anti-convulsant medication, and the post-operative EEG on December 17, 1955 was reported as follows:

Interpretation: This EEG is regular and rhythmic at a frequency of $7\frac{1}{2}$ -8/second. Except for the slight increase in the background frequency of fast waves from the right central region, and an occasional sharp deflection from this area, no specific abnormality is noted.

"In comparison with the previous EEG tracing, the spike wave localized to the right parieto-occipital region has disappeared. The EEG is stable to hyperventilation, and this correlates with the excellent clinical improvement in this case. There have been no seizures since the day of surgery.

EEG Diagnosis: EEG within normal limits, no evidence of convulsive tendency."

She has been free of seizures, has gained weight, and has developed skill in using her previously paretic left hand for such movements as operating a cigarette lighter, washing dishes, etc.

It is now seven months since surgery, and the patient is anxious to consider adoption of a child, a fulfillment which she could never previously contemplate, because of her physical incapacity and convulsive tendency.

Discussion

The two cases described in detail above are continued on page 262

CINEPLASTIC SURGERY

A Case Report

A. A. SAVASTANO, M.D.

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CINEPLASTIC SURGERY is that branch of surgery which concerns itself with the practical utilization of the muscular potential remaining in an amputated stump. The object of this type of surgery is to use the residual muscular power left in a stump to activate an artificial limb.

There is more than one method of cinematization. The methods generally used consist of:

- A. Mechanical cinematization—in which cases the muscles of the stump are utilized without surgery to activate an artificial limb.
- B. Surgical cinematization—in which a plastic surgical operation is done on the muscles of the stump as a means of activating the artificial limb.

Prior to the turn of the century, little or nothing was recorded as having been done in the development of this special field of surgery. Up to this time the surgical profession had been lax in this type of surgery, delegating any work on prostheses of any type to artisans. Historically, it is reported in the literature that a Roman by the name of Marcus Sergius, lost his right hand in the Second Punic War, and he had an artificial iron hand made for himself which did not function. The next references that are made in the literature are the artificial hands of a sea pirate by the name of Barbarossa Horuk and that of Goetz von Berlichingen in the year of 1504. During the second half of the sixteenth century, Ambroise Paré designed an artificial hand in which metal springs were used to achieve extension and flexion of the fingers.

Count de Beaufort, in 1867, is given credit for writing a paper dealing with the surgical treatment of activating the musculature of an amputated stump. The record does not state, however, as to whether or not his ideas were ever put into use. The first application of cineplastic surgery to any appreciable extent was done by Ceci of Pisa, Italy, who had obtained his ideas from Vanghetti, another Italian. Ceci is reported as having done numerous operations of this kind on wounded sol-

diers from the Abyssinian War of 1897. During and after World War I, Sauerbruch did a considerable amount of work on cineplastic surgery in Germany. He established definite and practical techniques for this type of surgery. Other names which have figured prominently in the development and popularization of cineplastic surgery include the names of Francesco, Putti, Pellegrini, Codovilla, Galeazzi, Elgart, Walcher and many others.

As cinematization stands today the method which is most practical is a so-called mechanical cinematization in which a so-called "artificial hook" is activated by the muscles of the extremity by mechanical means. The other method which is in use today is that of activating an artificial hand or arm by doing a canalization operation. In canalization operations, normal healthy skin with good sensation is tunneled through an active muscle belly. This will permit the canal to receive the contraction of the muscle and thereby activate an artificial hand through pegs which run through the canal and which are connected to the artificial hand by means of levers attached to springs. The muscles of the upper extremity which are most widely used include the pectoralis major, biceps brachii, triceps brachii, as well as any of the flexors or extensors of the forearm.

I wish to report the case of a forty-nine-year-old white male construction worker on whom a forearm canalization cineplastic operation was done. The patient in question was considered an excellent risk for this type of operation as he appeared to have all the necessary prerequisites for a successful end result. First, the condition of his local stump was very good in that the skin was healthy without any ulcerations whatever and with good nerve sensation.

The patient was very cooperative and he assured me that he would utilize the prosthesis to the best of his ability if one were made for him. He further was considered to be intelligent, stable, and one who would work hard to overcome any initial difficulties which are generally encountered in mastering the use of an artificial limb. In addition, his body build was such that he easily fell into the class in whom the potential power of the forearm flexors was 4-5 Kg. and the forearm extensor potential power 3-4 Kg.

continued on next page

Case Report: (G.D.) A forty-nine-year-old white male construction worker entered the Rhode Island Hospital, Providence, Rhode Island, on November 8, 1945, as a result of having caught his right hand in the gear of a concrete mixing machine. The patient was taken to the operating room where supportive care was given and the patient's hand injury was evaluated. He was found to have an extremely severe injury of the right hand and fingers to such a degree that it was impossible to anatomically recognize the individual structures of the hand. The tendons, nerves and soft tissues were shredded and devitalized. All of the phalanges, metacarpals and distal row of carpal bones were shattered in many small pieces. It was obvious that nothing could be done but to remove all devitalized tissues at the level of the wrist.

A thorough debridement was done. A flap of skin which came over the lesser thenar eminence appeared to be intact and therefore, this was saved in order to cover the stump. The amputation was completed at the radio-carpal joint. The ulnar, median, and radial nerves were isolated, retracted upward beyond the wrist, tied with black silk at this point and allowed to retract. The radial and ulnar arteries were located and tied at the level of the amputation. All tendons were sutured over the end of the stump. The full thickness skin which had been left over the lesser thenar eminence was turned over the end of the stump and sutured to the remaining free surfaces. An attempt was made to preserve all viable structures for possible future reconstruction procedures. A rubber drain was placed at the end of the stump. Skin traction and a massive dressing were applied. The patient re-

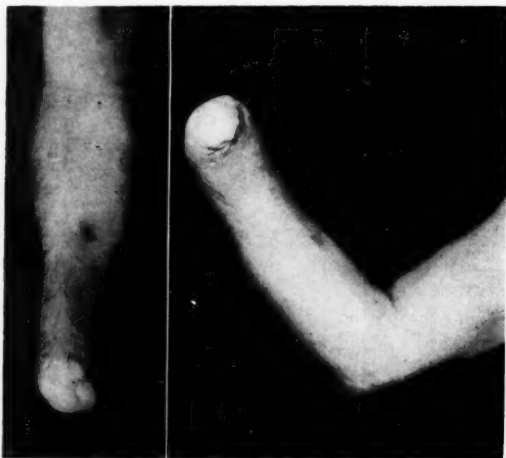
ceived plasma, blood and saline during the operation. He also received gas bacillus and tetanus antitoxin as well as anti-infection drugs. The patient's stump healed uneventfully, per primum. (Figures 1, 2.)

We now began to give thought to doing a cineplastic procedure at a later date; consequently, we began to look for neuromata formation and stump ulcers which remained entirely absent from the patient's stump. He was further put on massage and active exercises in order to reduce the atrophy of the stump muscles to a minimum. The exercises that he did consisted largely of flexing and extending his phantom fingers. By September of 1946, the patient was considered as being ready to undergo the definitive cineplastic operation. The patient was accordingly admitted to the hospital on September 24, 1946, where on September 26, 1946, a cineplastic operation was done. The procedure done was as follows:

Procedure: Under general anesthesia the forearm was divided into three imaginary thirds. A semi-circular incision was now made on the anterior aspect of the forearm at the junction of the middle and distal third of the middle third. The skin and subcutaneous fat were raised by blunt dissection and the fascia was split. The flexor digitorum sublimis and the flexor carpi radialis were located and a tunnel made through these muscles at a point near where the muscle substance joins the tendon substance. A skin flap was now raised which measured about $1\frac{1}{2}$ " in width and about $2\frac{1}{2}$ " in length starting at the ulnar side of the forearm and extending distally and laterally. The skin flap was now made into a tube with the skin on the inside of the tube. The entire tube was now passed through the split in the muscles above mentioned and the skin edge sutured to the skin edges on the other side, thereby making a skin tube through the muscles. The flap of skin first raised was now replaced with individual black silk sutures.

A similar procedure was done on the extensor side of the forearm using the extensor carpi ulnaris and the extensor digitorum communis as the muscles through which the skin tube was passed. A flap of skin was now undermined so as to leave the base of the ulnar side ventrally which was swung around and sutured in place in order to close the gap left by the skin which had been used to make the skin tube. A similar flap was used on the dorsal side except that its base was on the radial side. These flaps were approximated by means of black silk interrupted sutures.

Next the tendons of the flexor carpi radialis, flexor digitorum sublimis, extensor carpi ulnaris and extensor digitorum communis were isolated close to the amputation stump and were severed and allowed to retract upward. The remaining



FIGURES 1 and 2

(Fig. 1) Showing healed stump prior to cineplastic operation.

(Fig. 2) Showing healed stump prior to cineplastic operation.

structures were severed by means of a guillotine amputation and after retracting the soft tissue structures further up, the radius and the ulna were amputated about $3\frac{1}{2}$ " from the very distal end of the two bones. The radial artery was tied by means of heavy chromic catgut ties. All nerves were dissected up as far as possible and then severed and the distal ends tied with black silk. The stump was now closed after approximating over the stump all of the soft tissue structures except the tendons of the muscles through which the skin tubes had been passed. The skin was approximated by means of interrupted black silk sutures. Rubber tubes were passed through the skin tubes in order to keep the lumen open. At the completion of the operation, all of the skin appeared viable. An amputation stump dressing was applied and adhesive applied to each side of the arm in order to make traction of the skin. Supportive intravenous therapy was given throughout the operation.

The patient's postoperative course was uneventful with all of the wounds healing per primum and with the full thickness skin tunnel also healing without any untoward end result. Throughout the operation, the recommendations of the technical details suggested by Nissen and Bergmann were followed, namely that:

1. The canal was made short and wide and constructed at right angle to the direction of the muscle fibers.

2. The canal was made to pierce the muscles at a level which left two thirds of the thickness of the available muscle mass between it and the bone.
3. The internal suture line of the skin tube was placed proximally so that it would not be the subject of any tension or compression during contraction.

Immediately after the healing of all operative wounds, active massage and exercises of the musculature of the forearm was again started.

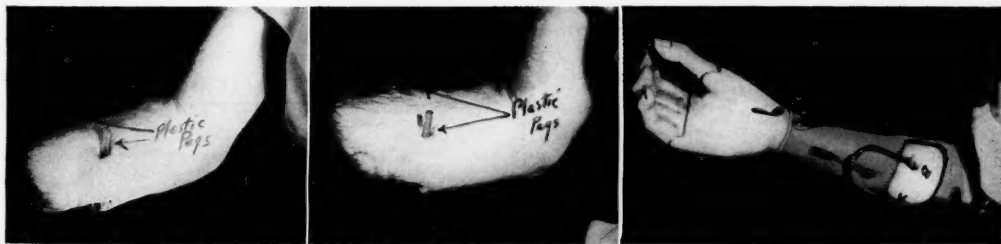
About one month after the operation, plastic pegs were made and introduced into the muscle canal and exercises were started against gradually increasing opposition strengths. (Figures 3, 4.)

The patient was fitted with his artificial hand on February 28, 1947, and he immediately began to practice so that by two months later he was able to manipulate the artificial hand with considerable dexterity. (Figures 5, 6.)

He learned to hold a match box in his hand and to write with the artificial hand, holding a pen between the thumb and index finger. He could pick up a telephone receiver and hold it to his ear during an everyday telephone conversation. He could use eating utensils and use the artificial hand to help himself dress. (Figures 7, 8.)

The patient was able to return to work with the construction company for which he worked at the

concluded on page 262

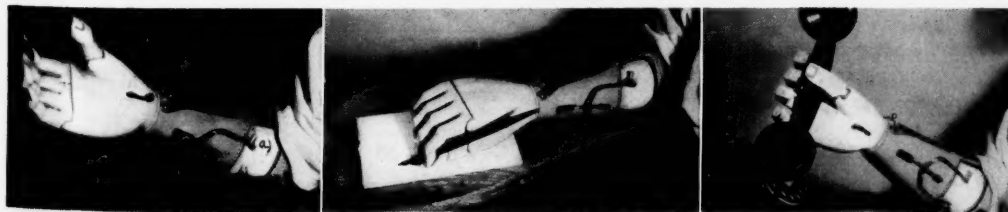


FIGURES 3, 4 and 5

(Fig. 3) Showing plastic pegs through skin tunnel which runs through muscle belly.

(Fig. 4) Showing plastic pegs through skin tunnel which runs through muscle belly.

(Fig. 5) Showing patient closing his artificial hand by contracting the muscles of his forearm. Horseshoe lever hooked to plastic peg (A & B) which is inserted in skin tube through muscles.



FIGURES 6, 7 and 8

(Fig. 6) Showing patient opening the artificial hand by relaxing the flexors of the forearm and contracting the extensors of the forearm. Horseshoe lever hooked to plastic peg (A & B) which is inserted in skin tube through muscles.

(Fig. 7) Showing patient holding pen in artificial hand. Was able to write letters.

(Fig. 8) Showing patient picking up a telephone receiver.

MASSIVE HEMORRHAGE FROM PEPTIC ULCER*

WARREN W. FRANCIS, M.D., AND PAUL T. WELCH, M.D.

The Authors. *Warren W. Francis, M.D., Surgical Resident, and Paul T. Welch, M.D., Junior Resident, Rhode Island Hospital, Providence, Rhode Island.*

THE PURPOSE of this paper is to review the experience at the Rhode Island Hospital with massive hemorrhage from peptic ulcer, in the year 1954, and to re-emphasize the high mortality associated with this entity.

Management of the mild or moderate bleeder is fairly well standardized and presents little material for discussion. The greatest problems of management arise in the case of the massive bleeder. Much of the confusion in the literature is due to the varying criteria used to establish the presence or absence of massive hemorrhage. Reported mortality rates in the treatment of this complication of peptic ulcer vary from one to forty per cent. This factor alone makes it quite obvious that the reports are concerned with cases of hemorrhage of varying severity.

In 1918 Finsterer advocated early operation for bleeding ulcer. However, up until the early 1940s, surgery was reserved for only the almost hopeless cases, after all types of medical therapy had failed. In the past few years there has been a renewed interest in the treatment of massive upper gastrointestinal hemorrhage, and the early use of surgery in carefully selected cases has been advocated.

In 1949, Amendola advised gastrectomy in the massively bleeding patient over fifty, who continues to bleed after twenty-four hours of adequate medical therapy. He also advocated gastrectomy for older patients with recurrent massive bleeding and those with pyloric obstruction or perforation superimposed on their hemorrhage. Stewart, Dunphy, Welch, Porter, and Harvey have also advocated early surgery on patients not responding to adequate medical therapy, and have emphasized the importance of avoiding tissue anoxia associated with hemorrhage, especially in the older patient.

Material

The increasing incidence of ulcer in the past thirty years is a well-known fact, and the number

*Presented at a Friday Surgical Conference, II Surgical Service, at Rhode Island Hospital.

of patients admitted with gastrointestinal bleeding from ulcer has risen progressively since 1924. (Table I)

TABLE I
Patients Admitted with Upper Gastrointestinal Hemorrhage from Ulcer

| Year | Number | (Total Admissions) |
|-----------|--------|--------------------|
| 1924..... | 5 | 8,903 |
| 1934..... | 14 | 9,952 |
| 1944..... | 23 | 13,053 |
| 1954..... | 101 | 15,337 |

In 1954, at the Rhode Island Hospital 101 patients were treated for upper gastrointestinal hemorrhage from ulcer. These have been divided into three groups. (Table II) The massive bleeders were only those patients who showed clinical evidence of shock. The moderate bleeders were those with hemoglobins below eight grams, but with no clinical evidence of shock. The mild bleeders included all others who did not fit into the first two categories.

TABLE II

| | |
|----------------|--------------|
| Massive | 18 Patients |
| Moderate | 29 Patients |
| Mild | 54 Patients |
| Total | 101 Patients |

The age distribution and sex incidence of the massive bleeders is shown (Table III) and is consistent with most other reports.

TABLE III
A. Sex Incidence Massive Bleeders

| | |
|--------------|-------------|
| Male | 14 Patients |
| Female | 4 Patients |

B. Age Distribution Massive Bleeders

| | |
|---------------|------------|
| 40-50 | 4 Patients |
| 51-60 | 4 Patients |
| 61-70 | 7 Patients |
| Over 71 | 3 Patients |

Types of Therapy

Therapy employed has been divided into three groups. 1) Medical; 2) emergency surgery (this

group was operated on during the bleeding episode); 3) elective surgery (after the bleeding episode had stopped). The duration of hospitalization for these patients (Table IV) has no significant differences apparent.

TABLE IV
Duration of Hospitalization

| | Range | Average |
|-------------------|------------|---------|
| Medically treated | 10-22 Days | 16 Days |
| Emergency surgery | 14-36 Days | 19 Days |
| Elective surgery | 12-23 Days | 18 Days |

Of the twelve patients undergoing surgery, all had subtotal gastrectomies performed. Effort was made to remove the bleeding point whenever possible. (Table V)

TABLE V
Management of Bleeding Point

| | |
|---------------------|---|
| Left in | 3 |
| Removed | 7 |
| Exteriorized | 1 |
| Not indicated | 1 |

The problem of what to do at operation, when the source of bleeding cannot be determined, is a difficult one. Gray reported in 1954, on a total of forty-eight patients in whom a similar situation arose. Twenty were treated with gastrectomy and in twenty-eight no gastrectomy was performed. In those patients who underwent gastrectomy, there was a recurrence rate of 11%, and in those patients on whom no gastrectomy was performed there was a 63% recurrence rate. This situation did not arise in this series. Stewart advised an adequate gastric resection, even though no evident ulceration could be identified. His reasoning, that by so doing one would eliminate the location and source of 95% of the bleeding, has been widely accepted.

The number of transfusions administered varied greatly, and the incidence of transfusion reaction was slight; none being severe. (Table VI)

TABLE VI
Number of Transfusions

| | |
|-------------------------|------|
| Medical | 1-9 |
| Emergency surgery | 2-14 |
| Elective Surgery | 2-8 |

Number of Transfusion Reactions

| | |
|--------------|---|
| Slight | 3 |
|--------------|---|

Emergency gastrointestinal series, using the Hampton technique, was employed in nine cases, and a positive diagnosis was made in all of these.

Results of Therapy

The results are summarized (Table VII) and the high mortality rate associated with massive gastrointestinal bleeding is obvious.

TABLE VII

| | Patients | Died | Mortality |
|---------------------|----------|------|-----------|
| A. Massive | 18 | 7 | 40% |
| Medical | 6 | 4 | 67% |
| Emergency surgery | 9 | 3 | 33% |
| Elective surgery .. | 3 | 0 | 0% |
| B. Moderate | 29 | 1 | 3% |
| Medical | 21 | 1 | 5% |
| Surgery | 8 | 0 | 0% |
| C. Mild | 54 | 0 | 0% |
| Medical | 34 | 0 | 0% |
| Surgery | 20 | 0 | 0% |
| Total | 101 | 8 | 8% |

Mortality

Analysis of the deaths in the medically treated group revealed that three died from exsanguination, and one from a hemolytic staphylococcus pneumonitis. Of the three patients who exsanguinated while on medical therapy, one had a metastatic malignancy, another had a sudden fatal hemorrhage while being treated for cardiac decompensation, and the third was seen in consultation by the Surgical Service, who felt that his general condition was too poor to tolerate any surgical procedure. Of the three deaths in the patients treated with emergency surgery, one was from peritonitis secondary to an anastomotic leak, and the other two were unexplained as no postmortem examinations were obtained. (Table VIII) All deaths in the massively bleeding group were patients over fifty years of age.

TABLE VIII
Cause of Death

| | |
|-----------------------------------|---|
| A. Medical | |
| Exsanguination | 2 |
| Terminal carcinoma | 1 |
| Pneumonitis | 1 |
| B. Emergency Surgery | |
| Peritonitis from Anastomotic leak | 1 |
| Unknown | 2 |

Comment

Although this small series is not statistically significant, the high mortality associated with the medical treatment of massive bleeding is noted, and the indication for early surgery in selected cases is apparent.

SUMMARY

The management at the Rhode Island Hospital of massive hemorrhage from ulcers of the upper gastrointestinal tract is based on the same principles of adequate blood replacement and early operation to prevent shock and tissue anoxia that are followed in most other clinics. The high total mortality rate

concluded on next page

of 40% in 1954, is closely related to the older age group being treated and to the associated diseases encountered which often make what could be life-saving surgery impossible. In order to reduce this high mortality rate, it will be necessary to convince our medical confreres that the recurrent ulcer is a surgical problem and that, in these individuals, surgery alone can eliminate the devastating complications of hemorrhage, obstruction and perforation.

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CINEPLASTIC SURGERY

concluded from page 259

time of his injury. His work, however, consisted of driving pick-up trucks, directing traffic, acting as foreman and doing some clerical work. Both the patient and myself were very well pleased with the outcome of the procedure described.

It is true that an artificial hand is not as serviceable as a mechanical hook; however, some patients object to the cosmetic appearance of a mechanical hook. It is to be further noted that the patient who has a cineplastic operation done can also utilize the mechanical hooks if he so desires.

CONCLUSIONS

1. A case report is presented in which a forty-nine-year-old white male construction worker lost his entire right hand when he caught it in the gears of a concrete mixing machine.
2. A cineplastic operation was done on this patient on whom the flexor and extensor muscular mechanism of the forearm were utilized.
3. An artificial hand was fitted which the patient was able to use rather proficiently only eight weeks after obtaining the hand. He was able to write with

the artificial hand, hold a telephone receiver, hold a match box, hold eating implements and he became able to dress and undress himself without help.

4. The doing of a cineplastic operation on an upper limb does not render that limb unsuitable for fitting with a mechanical hook as well.

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INTRACRANIAL SURGERY FOR HEMIPLEGIA AND CONVULSIONS

continued from page 256

sidered to be cases of unilateral cerebral atrophy according to the classification proposed by Silver, Denhoff and Holden. These are cases in which a prenatal or paranatal injury involving one cerebral hemisphere results in the early appearance of spastic hemiparesis involving the extremities of the opposite side of the body. During development in infancy and childhood, the area of atrophy apparently increases in size, or at least the effects of traction secondary to gliosis become more pronounced. With early adolescence, and in particular at about the time of the menarche in female children, seizures tend to occur or recur. These seizures are refractory to ordinary doses of anti-convulsant medication. At such time, appropriate diagnostic studies confirm the existence of a cerebral scar either as a porencephalic cyst or traction scar involving the ventricles.

Electroencephalographic studies at this time reveal focal cerebral dysrhythmia, usually in the form of high voltage spike-wave discharges from an area corresponding to the zone of maximal cortical irritability.

Surgical excision of this epileptogenic focus can bring about relief from seizures, presumably by virtue of actual removal of epileptogenic cortex, as well as by reduction of transmitted electrical discharges to neighboring zones of cortex.

The primary purpose of the surgery is to reduce or eliminate the seizures. However, a very gratify-

ing parallel development has been the reduction in spasticity of the opposite arm and leg, and with the reduction of spasticity, an apparent increase in motor power and increase in coordination in the use of the upper extremity. This finding confirms the observations of other authors, and although the correct interpretation of the finding is still obscure, it would appear to be the result of elimination of abnormal local electrical activity so as to permit greater control over the diseased cortex by other portions of the brain. The spasticity, then, is the resultant of a heightened cortical discharge in the motor area, and although this area has long since been supplanted by other regions of the cerebral cortex which initiate movement of the extremity, a control of such movement has been effected by local neuronal mechanisms which are constantly active. Presumably, it is the removal of these abnormally active local circuits which permits clinical improvement in coordination.

SUMMARY

Two cases are presented which illustrate effective control of convulsions, and improvement in spastic hemiplegia, by surgical excision of atrophic cerebral cortex, over a unilateral porencephalic cyst.

These cases emphasize that infantile hemiplegia with convulsions may be benefited by intracranial surgery.

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120 BROADWAY, NEW YORK 5, N. Y.

Basil O'Connor, President

April 20, 1956

Dr. Frank B. Cutts, President
Rhode Island Medical Society
106 Francis Street
Providence, Rhode Island

Dear Doctor Cutts:

May I take this opportunity, on the occasion of the annual meeting of the Rhode Island Medical Society to express thanks from the National Foundation for Infantile Paralysis to the society as a whole and to its individual members for their excellent cooperation with the state health department and the National Foundation in the successful conduct of the poliomyelitis vaccine demonstration program in Rhode Island during 1955.

The chief beneficiaries of this program, of course, were the Rhode Island school children, mainly in the first and second grades, who received one or more injections of vaccine supplied by the National Foundation during the year 1955. A total of 68,976 cc. of vaccine was supplied.

You may be interested to know that, thanks to your help, 33,490 Rhode Island children received at least one inoculation; 22,498 received two inoculations; and 1,682 received a third (booster) inoculation.

Approximately 52% of the Rhode Island children in the 5-9 age group, the age group most susceptible to paralytic poliomyelitis, thus obtained a high degree of protection against the disease in 1955 as a result of this program.

The cooperation of the Rhode Island Medical Society helped materially to account for this fine record.

While this is a formal expression of gratitude for your help, the real expression must come from the parents of those many children in Rhode Island who feel free from the threat of paralytic poliomyelitis in their families now that the 1956 poliomyelitis season is at hand.

Very cordially yours,

HART E. VAN RIPER, M.D., *Medical Director*

GENERAL PRACTICE CHAPTER ELECTS

At its annual dinner, the Rhode Island Chapter, American Academy of General Practice, elected the following officers for 1956-57:

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RHODE ISLAND MEDICAL JOURNAL

1942 — 1956

PETER PINEO CHASE

THERE ARE SOME MEN so happily endowed by nature that in them the wisdom of maturity is subtly interfused with the gaiety and enthusiasm of youth; they radiate friendliness and endear themselves to their friends more by what they are than by what they say or do; their wit has point but never inflicts pain; their minds are versatile instruments and not merely receptacles; they dignify their lives by practical activity and enhance their leisure hours by the enjoyment of beauty and the pursuit of learning. Such a man was Peter Pineo Chase, so recently taken from us.

The gifts of his ancestors were many, — a robust body which served him well in sports, a vivid imagination, a standard of values solidly based upon those virtues which have always formed the New England character. He was a medical humanist, a vibrant person, as much at home among the literary doctors in the Davenport collection as among the more pedestrian authors of medical texts. He never bore fools gladly, but for years he wrote a unique and nationally famous column in the daily press wherein he answered the questions of inquirers, who will miss him sadly, with clarity, humor and urbanity. His writings in the press were symbolic of the man; and from them one could easily compose a salty anthology of sound common sense in medicine.

Doctor Chase was from his youth a lover of books and no one more than he could appreciate the truth of Cicero's remark that "he who builds a library in his home gives that home a soul." For years Doctor Chase collected all the books he could lay his hands on by and about Doctor Johnson, and to hear him converse about Johnson, Boswell and the rest one would almost believe that they were near neighbors. He was especially interested in Johnson's infirmities and the writer vividly recalls an occasion when Doctor Chase talked about the illnesses of Johnson to the obvious pleasure of his interested medical audience. There must indeed have been something in Johnson's temperament which struck a responsive chord in Peter Chase. Could it have been the Johnsonian forthrightness or perhaps, even his brusqueness?

As editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL, Doctor Chase for years devoted much thought and labor with the result that our Journal holds an honorable place among medical publications. We, his colleagues who always admired and respected him, will hold him in grateful and inspiring memory as a conscientious worker in surgery, a fine citizen and a charming friend.

The RHODE ISLAND MEDICAL JOURNAL

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DOCTOR DANFORTH MEDICAL SCHOLARSHIPS

Miss Agnes H. Danforth of Bangor, Maine, has just left in her will a bequest of \$10,000 to establish the Doctor Murray Snell Danforth Fund, the income from which will be used to award scholarships to residents of Maine who are students at Bowdoin College preparing for the medical or related professions. Those of us here who feel fairly mature in medicine will remember that Doctor Danforth became president of our State Society in 1943 when he was a tremendously sick man and that he died two days later and therefore, of course, never actively functioned as a president. We know that had he been in the good physical condition that we thought he was in at the time he was made president-elect he would have been a power in the presidency. He never took on any duties which he did not carry out conscientiously and with great ability. Many things in his career showed that.

Born in Eastern Maine he was a thorough Down-easter and went to Bowdoin College. From here he went to Johns Hopkins Medical School which was, of course, the equal of any school in the country. Doing graduate work at the Massachusetts General Hospital and under Sir Robert Jones in England, he took his regular internship at the Rhode Island Hospital thereby gathering from his rotating services a very broad knowledge of medicine which was an excellent background for his life work as

an orthopedic surgeon.

He rose high in this as shown by the fact that although practicing in this relatively small community away from any medical school, he nevertheless was the editor of the outstanding orthopedic journal in the world one might say, as it represented the orthopedic societies of both the United States and Great Britain. Of course his worth in this State was well known to us all and received full recognition.

We think that it is fitting that his sister should remember his College to which he was always devoted and is doing this to encourage the study of medicine by Maine boys for we presume that most of Bowdoin's undergraduate body comes from this State. We have been told that Maine needs more doctors as there is a large proportion of osteopathic and chiropractic practitioners in their State.

When Abraham Flexner did his remarkable work leading to the reorganization of medical education in this country he closed a large number of medical schools of little value. It is hard to do a thorough cleaning-up job without some injury to things in the vicinity, and one sad part of his work was the closing of the Bowdoin Medical School. It may not have been too strong a school at that day, but we believe that it should have been built up rather than closed.

Presumably there is no chance of a medical school in Maine now, but this bequest ought to help Maine boys to a good start in medicine.

concluded on page 287

IMPORTANT RESEARCH CONTRIBUTION

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President of the Rhode Island Medical Society
1956 - 1957

PRESIDENT'S MESSAGE

IN ASSUMING the presidency of the Rhode Island Medical Society I am fully appreciative of the responsibility of the office and I am also cognizant of the record of my illustrious predecessors who served medicine so faithfully and well. It is my sincere desire to emulate their accomplishment to the best of my ability and to help guide the activities of the Society in its service to humanity during my incumbency.

My immediate predecessor, Doctor Frank Cutts, in his presidential address called attention to the activities of the Society and stressed the opportunities for the members to participate in shaping the course of medicine.

I would like at this time to further emphasize the absolute necessity of active participation in the activities of the Society by every member who is able to spare even a small portion of his busy life to the affairs of medicine, because, in our rapidly changing world we can no longer be content merely to practice "physic" and let the mundane affairs of economics and social welfare fall to others.

The physician is an important member of society and he must discharge that obligation by participation in the socio-economic activities of the community.

We in medicine have made tremendous strides in the scientific field and pay close attention to the progress of our strictly professional interests. But if our patients are to have the fullest value and use of the advances of medicine it is imperative that we participate in the planning, and the distribution of, improved medical care.

To that end your Society has elected certain Standing Committees and I have appointed several other Committees for specific purposes. I urge all members to cooperate with, to consult with, and to call upon these Committees, so that the full potential of medicine's contribution to community life can be utilized in providing better health care for all.

Many areas and certain subjects require special attention and as the months roll on I intend to issue special messages to cover them, and I ask your attention and cooperation.

With God's help and yours I am sure we will have a year of accomplishment.

CHARLES L. FARRELL, M.D., *President*

OFFICERS INSTALLED FOR 1956-57

DOCTOR CHARLES L. FARRELL, Pawtucket physician, was installed on May 2 as the ninety-seventh president of the Rhode Island Medical Society, the nation's ninth oldest state medical association. He succeeded Doctor Frank B. Cutts, of Providence. The installation took place during the general business session in connection with the 145th Annual Meeting of the Society at the Medical Library.

Named as president-elect to succeed Doctor Farrell a year hence was Doctor George W. Waterman, Providence surgeon who is currently president of the New England Surgical Society. Elected to the vice-presidency was Doctor Joseph C. Johnston, of Providence.

Doctor Thomas Perry, of Providence, was re-elected secretary for his fifth term in that office, and Doctor John A. Dillon, of Providence, was renamed treasurer for a fourth term.

Doctor Farrell has been one of the Society's most active workers. He has headed numerous committees, particularly those concerned with industrial health and health insurance for many years, and he was the Society's delegate to the American Medical Association for six years. He is currently president of the National Conference of Presidents and Other Officers of State Medical Associations, and he is a past president of the Association of American Physicians and Surgeons. He was named a year ago as one of seventeen citizens picked from the entire country to serve as consultants to the Federal Department of Health, Welfare and Education on the disability provisions of the amended Social Security Act.

A graduate of Tufts Medical School, Doctor Farrell established his office for the general practice of medicine and surgery in Pawtucket in 1925. He holds degrees as a Doctor of Dentistry and as a Doctor of Pharmacy in addition to his medical degree.

Doctor Johnston, Vice President

Doctor Joseph C. Johnston, a graduate of Brown University and Tufts College Medical School and a past president of the New England Industrial Medical Association, succeeds Doctor John G. Walsh as vice president of the Society. A native of Providence, Doctor Johnston returned here to establish his practice of general medicine and sur-

gery after the completion of internships at Boston City, Rhode Island and Providence Lying-In hospitals. He is on the staff of the Rhode Island, Saint Joseph's, Chapin, Lying-In, Roger Williams General and Our Lady of Fatima hospitals. He is also chairman of the Society's committee advisory to the State Department of Employment Security relative to its temporary disability program.

Cancer Society Leader President-Elect

Doctor George W. Waterman, chosen to succeed to the presidency next year, has long been identified with the Cancer Committee activities of the Society, and he also served as president of the Rhode Island Cancer Society for five years. A native of Providence, he was graduated from Brown University and then completed his medical school training at Cornell Medical College. He served internships at New York Memorial and New York hospitals and Lying-In Hospital in that same city, before returning to Providence to establish his practice in obstetrics and gynecology.

Doctor Waterman was president of the Providence Medical Association in 1949, and he is a former surgeon-in-chief of the Department of Gynecology of the Rhode Island Hospital.

Committee Chairmen Named

The House of Delegates, policy making body of the Society, elected the official standing committees in addition to the officers naming as chairmen of these committees the following: Scientific Work and Annual Meeting, Doctor Marshall N. Fulton, of Providence; Industrial Health, Doctor Stanley Sprague, of Pawtucket; Public Laws, Doctor James H. Fagan, of Providence; Public Policy and Relations, Doctor Arnold Porter, of Providence; Library, Doctor Irving A. Beck, of Providence; Medical Economics, Doctor Gustavo A. Motta, of Providence; and Publications, Doctor Charles J. Ashworth, of Providence.

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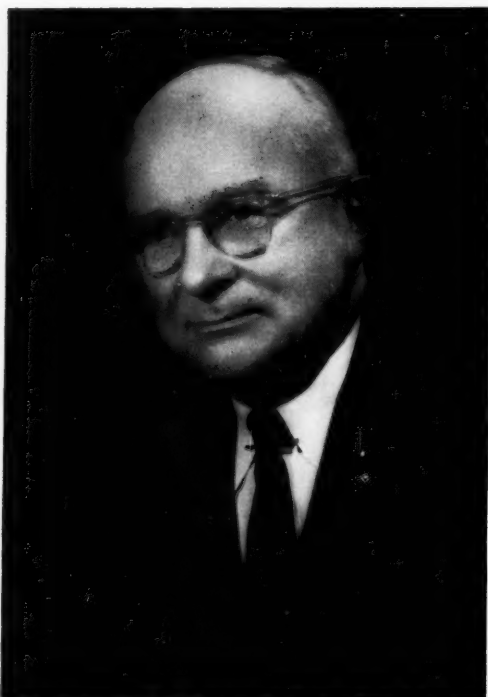
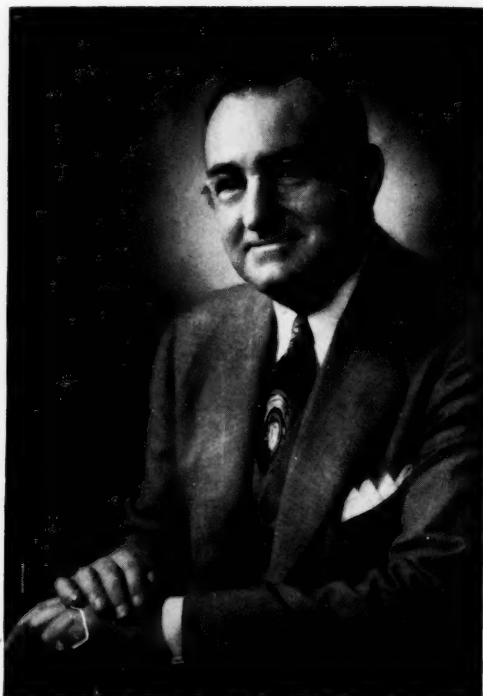
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1. Spies, T. D., et al.: GP 12:73, No. 1,
1955. 2. Boland, E. W.: J.A.M.A.
160:613, 1956. 3. Gillhespy, R. O.:
Lancet 2:1393, 1955.

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JOSEPH C. JOHNSTON, M.D.
of Providence, Rhode Island
Vice President of the Rhode Island
Medical Society, 1956-1957



GEORGE W. WATERMAN, M.D.
of Providence, Rhode Island
President-Elect of the Rhode Island
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OFFICERS AND ELECTED COMMITTEES — 1956-1957

THE RHODE ISLAND MEDICAL SOCIETY

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Vice President: JOSEPH C. JOHNSTON, M.D., Providence
President-Elect: GEORGE W. WATERMAN, M.D., Providence
Secretary: THOMAS PERRY, JR., M.D., Providence
Treasurer: JOHN A. DILLON, M.D., Providence

STANDING COMMITTEES

(Providence district unless indicated otherwise after name)

President and Secretary, *ex officio*, and 9 members elected by the House of Delegates*Scientific Work and Annual Meeting*

Marshall N. Fulton, M.D., *Chairman*
 J. Murray Beardsley, M.D.
 Frank B. Cutts, M.D.
 Eric Denhoff, M.D.
 Thomas Forsythe, M.D.
 Hannibal Hamlin, M.D.
 Erwin O. Hirsch, M.D.
 William A. McDonnell, M.D.
 William B. O'Brien, M.D., Wallum Lake

Industrial Health

Stanley Sprague, M.D., *Chairman*, Pawtucket
 Thomas J. Dolan, M.D.
 John S. Dziob, M.D.
 Augustine W. Eddy, M.D., Woonsocket
 Arcadie Giura, M.D., Warren
 Charles J. Hutchinson, M.D.
 Joseph C. Johnston, M.D.
 A. Lloyd Lagerquist, M.D., Riverside
 Paul J. Rozzero, M.D.

The Library

Irving A. Beck, M.D., *Chairman*
 Philip Batchelder, M.D.
 Seebert J. Goldowsky, M.D.
 Martin J. O'Brien, M.D., Wickford
 Bernard Rapoport, M.D.
 Jeannette E. Vidal, M.D., West Warwick
 Francis P. Vose, M.D., Woonsocket
 Richard K. Whipple, M.D.
 Elihu S. Wing, Jr., M.D.

Medical Economics

Gustavo A. Motta, M.D., *Chairman*
 E. Arthur Catullo, M.D.
 Robert C. Hayes, M.D., Pawtucket
 Kieran W. Hennessey, M.D., Pawtucket
 Frank J. Logler, M.D., Newport
 James A. Reeves, M.D.

Stanley D. Simon, M.D.

Eske Windsberg, M.D.

Peter C. H. Erinakes, M.D., West Warwick

Public Laws

James H. Fagan, M.D., *Chairman*
 Freeman B. Agnelli, M.D., Westerly
 Herbert E. Harris, M.D.
 Albert H. Jackvony, M.D.
 Francis D. Lamb, M.D., West Warwick
 Joseph B. McKenna, M.D., Woonsocket
 Edward A. McLaughlin, M.D.
 William A. Reid, M.D.
 Edward H. Trainor, M.D., Pawtucket

Publications

Charles J. Ashworth, M.D., *Chairman*
 Alex M. Burgess, Sr., M.D.
 John A. Dillon, M.D.
 John E. Donley, M.D.
 Herbert Fanger, M.D.
 Henri E. Gauthier, M.D., Woonsocket
 Seebert J. Goldowsky, M.D.
 William J. MacDonald, M.D.
 Earl J. Mara, M.D., Pawtucket

Public Policy and Relations

Arnold Porter, M.D., *Chairman*
 Harry E. Darrah, M.D.
 Frederick C. Eckel, M.D., Westerly
 Hubert Holdsworth, M.D., Bristol
 Thomas J. Lalor, Jr., M.D., Woonsocket
 Ernest K. Landsteiner, M.D.
 Jose M. Ramos, M.D., Newport
 Charles B. Round, M.D., Warwick
 Hrad H. Zolmian, M.D., Pawtucket

Auditors

Frank B. Cutts, M.D.
 Henri E. Gauthier, M.D., Woonsocket

Officers, 1956-1957 THE RHODE ISLAND MEDICAL SOCIETY



THOMAS PERRY, JR., M.D.
of Providence
Secretary



JOHN A. DILLON, M.D.
of Providence
Treasurer



CHARLES J. ASHWORTH, M.D.
of Providence
Delegate to the AMA



ARTHUR E. HARDY, M.D.
of Edgewood
Alternate Delegate
to the AMA



JOHN E. FARRELL, SC.D.
of Rumford
Executive Secretary

JANUARY SESSION, 1956
THE RHODE ISLAND GENERAL ASSEMBLY
House Resolution 1166

Upon the death of Doctor Peter Pineo Chase, of Providence, Rhode Island, physician and surgeon, widely known for his intimate and human column in the PROVIDENCE JOURNAL-BULLETIN, known as *You and Your Health*

THE MEMBERS of the General Assembly, many of whom were devoted readers of the intimate, epigrammatical and human column in the PROVIDENCE JOURNAL-BULLETIN, known as *You and Your Health*, under the authority of Dr. Peter Pineo Chase, of Providence, Rhode Island will be shocked at the tragic news of his sudden death upon Monday, April 23, 1956.

He was a physician and surgeon, but he had many, many other interests for he was a noted athlete during his college days, a mountain climber and a skier, a lover of classical literature, an author and traveler.

Dr. Chase was internationally and nationally recognized for his medical column for which he had been writing since 1946. As the morning JOURNAL summarized:

"His was a column different from all medical columns that were ever written. Couched in forthright colloquial English, it was readable, cheerful and salted with a dry and pungent wit. He punctured many a blown-up fallacy, and did it engagingly. One of his best known sayings: 'In my opinion there's just one thing that's done more damage to the human race than the internal combustion engine, and that's the blood pressure machine.'"

Dr. Peter Pineo Chase stemmed from Yankee and French Huguenot ancestry. His maternal grandfather was a remarkable man in many ways, a skilled surgeon and a bold thinker. In the old Pineo homestead upon Cape Cod young Peter was born August 26, 1878, imbued with the saltiness of Yankee speech and sounding sea. He was educated in Hyannis and Barnstable, Brown University and Harvard Medical School.

He rose high in his profession, became renowned as a surgeon at the Rhode Island Hospital and the Providence Lying-In Hospital, was first secretary and then president of the Providence Medical Association and president of the Rhode Island Medical Society.

In World War I he went to France with a Harvard Medical Unit, served as a surgeon with the British Army.

When the United States entered the war he transferred to the AEF with the rank of captain and surgeoned the wounds of all the offensives that

pushed Germans back to the Rhine.

In World War II he went back into hospital work and after the war was over was one of a group of doctors who went to Germany to give refresher courses in medicine and surgery to European DP medicos, a project sponsored by the International Refugee Organization, Unitarian Service Committee, American Joint Distribution Committee, the Society of Friends and Church World Service; now, therefore, be it

RESOLVED, That this General Assembly, deeply regretful of the far reaching loss to so many by reason of the death of Dr. Peter Pineo Chase, now extend to the widow sincere sympathy in this bereavement; directing the Secretary of State to transmit to her a duly certified copy of this resolution.

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CONNECTICUT STATE MEDICAL
SOCIETY RESOLUTION ON THE
DEATH OF PETER PINEO CHASE, M.D.

WHEREAS; Dr. Peter Pineo Chase, past-president of the Rhode Island Medical Society and editor of that Society's Journal, was called to his reward on April 23, 1956, at the age of 78; and

WHEREAS; Dr. Chase has represented the highest qualities in the practice of medicine; and

WHEREAS; Dr. Chase has contributed over a period of years to increasing the knowledge of the public in the fundamental principles of health and good living by his pertinent statements appearing in the local press; and

WHEREAS; Dr. Chase, because of his friendliness and qualities of leadership, will be sorely missed not only by his colleagues in Rhode Island, but also by his many friends throughout the United States; therefore

BE IT RESOLVED; that the House of Delegates of the Connecticut State Medical Society, at its Annual Meeting on April 24, 1956, expresses his deep sorrow at the loss of Dr. Chase at a time when his valuable counsel will be sorely missed; and further

BE IT RESOLVED; that a copy of this resolution be spread on the minutes of this House of Delegates and a copy sent to the Secretary of the Rhode Island Medical Society and to the widow of the deceased.

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DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual business meeting of the Pawtucket Medical Society was called to order by Dr. Hanley on March 15, 1956 at 12:00 noon.

The following members were present—Doctors Mathewson, Sonkin, Zolmian, Kalcounas, Czekanski, Hayes, Hecker, Morris, E. Gaudet, Hennessey, Ruggles, O'Neil, R. T. Stevens, Mara and F. Hanley. Dr. Ruggles presented the annual treasury report.

Dr. E. Gaudet moved that the annual dues for 1956-1957 should be \$20.00. This was seconded and passed.

Dr. F. Hanley gave an address as out-going president. The title was "Why do we have a Pawtucket Medical Society and what is the function of

a district society?" The speech was received with general applause.

Dr. James P. Healey proposed the following slate of nominees as officers:

President, R. Thomas Stevens, M.D.
Vice President: Martin J. Morris, M.D.
Treasurer: Mary E. Rohr, M.D.
Secretary: Nathan Sonkin, M.D.
Councillor: Earl J. Mara, M.D.

Delegates: James P. Healey, M.D.; Harold A. Woodcome, M.D.; Hrad H. Zolmian, M.D.; Robert Hayes, M.D., and Henry E. Turner, M.D.

The secretary was instructed to cast the ballot and the entire slate was passed unanimously.

Dr. R. T. Stevens accepted the chair from Dr. F. Hanley. Dr. Stevens then proceeded to nominate several members for various committees for the ensuing year.

Communications were next brought up. The first was a communication from the Rhode Island Medical Society in regard to HR 7225, social security amendment act urging individual members to send telegrams to the Rhode Island senators urging a recommendation for complete review of the social security system rather than to make amendments such as proposed by HR 7225.

The next communication from the Rhode Island Medical Society was in regard to a bill before the House Committee in Rhode Island to allow chiropractors to treat persons on public assistance thus exposing them to inferior care at state expense. This communication urged individual members to defeat this bill "Senate 60."

Both communications were discussed and it was the consensus of opinion that any action taken should be by individual members as this was the intention of the Rhode Island Medical Society in bringing these communications to our attention. The meeting was adjourned at 1:00 P.M. to reconvene for the dinner at the Lindsey Tavern for the doctors and their wives.

Respectfully submitted,
NATHAN SONKIN, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held on Monday, April 2, 1956.



R. THOMAS STEVENS, M.D.
President, 1956
The Pawtucket Medical Association

The meeting was called to order by Dr. Robert R. Baldrige, President, at 8:30 P.M.

The minutes of the previous meeting were not read.

Communications

The Secretary reported an invitation from the Rhode Island Conference on Social Work to the physicians of the Providence area to attend a dinner meeting of the Conference to be held on April 5, 1956.

Report of the Executive Committee

The Secretary reported that at a recent meeting the Executive Committee took the following actions:

1. It approved of the transfer of Dr. Paul B. Metcalf to active membership in the Pawtucket Medical Association and to associate membership in the Providence Medical Association.
2. It recommended that a questionnaire be prepared for use by all members answering emergency calls for a physician received through the Medical Bureau to determine the extent of the emergency and the justification for the call for special service.
3. It approved of the plans of the Entertainment Committee to hold the Annual Dinner and Golf Tournament at the Rhode Island Country Club in Barrington on Wednesday, June 6.
4. It approved of the purchase of a 35 mm. projector for use at scientific and other meetings of the Association, and it also approved a proposal to share the expense for audio amplification for the auditorium with the Rhode Island Medical Society.

Announcement by the President

Dr. Baldrige urged the membership to attend the Annual Session of the Rhode Island Medical Society to be held on May 1, 2, and 3.

He also announced that the Annual Dinner and Golf Tournament would be held Wednesday, June 6, at the Rhode Island Country Club.

Applications for Membership

The Secretary reported that the executive committee recommended for election for active membership in the Association the following: Paul Neiberg, M.D., and Gunnar Nirk, M.D.

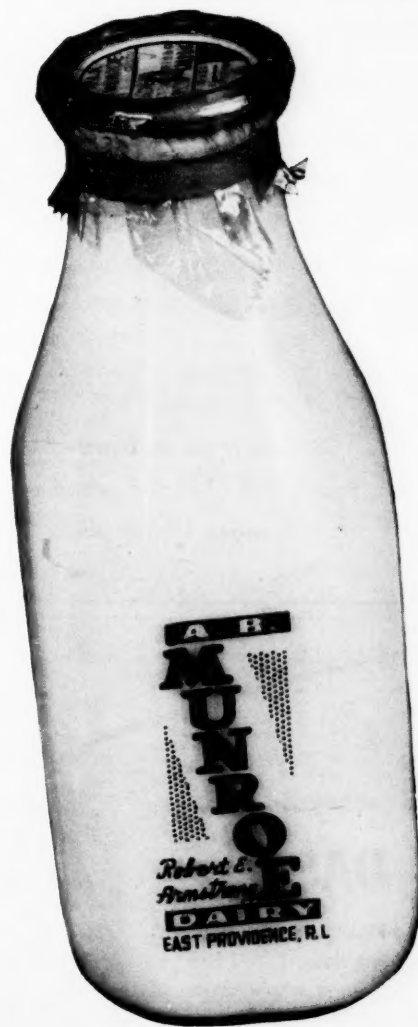
Action: It was moved that these physicians be elected to active membership. The motion was seconded and adopted.

Scientific Program

Dr. Baldrige introduced Dr. Louis Weinstein, Associate Professor of Medicine at Boston University School of Medicine. He announced that he

continued on next page

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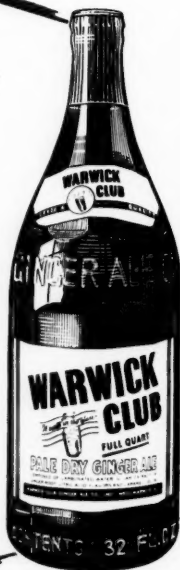
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and his colleagues would discuss the subject *Complications of Some Widely-Used Drugs*.

In his introductory remarks, Dr. Weinstein outlined three stages through which a newly introduced drug passes when it is available for general use. They are as follows:

1. Stage of uncontrolled enthusiasm: lack of experience.
2. Stage of doubt: untoward reactions.
3. Stage of proper application of the drug through experience: a) limitations of the drug, b) indications of the drug, and c) side effects of the drug.

Dr. Weinstein introduced the first panelist as Dr. J. Edwin Wood, Research Fellow in Medicine at the Boston University School of Medicine.

Dr. Wood pointed out that Hydralazine may produce an L.E.-like syndrome. It occasionally produces a rash, arthralgia, headache and angina.

Hexamethonium may produce serious side effects such as collapse and occasionally myocardial infarction. Blurred vision and bladder atony are other problems encountered with the use of this drug.

The next panelist was introduced as Dr. Arnold Relman, Assistant Professor of Medicine, Boston University School of Medicine.

Dr. Relman's remarks were confined to the following steroids: ACTH, Cortisone, Hydrocortisone, Prednisone and Prednisolone. The main side effects encountered with these drugs were the development of Cushing's syndrome with all the usual symptoms and signs and laboratory and metabolic changes. Another important side effect is the development of a diabetic-like picture especially in patients who have the diabetic tendency. He also pointed out that the steroids may destroy the normal anti-inflammatory processes of the body and may also mask dangerous inflammatory conditions. Steroid therapy may also produce personality changes and psychoses. Steroids may interfere with normal reactions to stress with the production of adrenal atrophy. Patients who are on steroid therapy cannot tolerate surgical procedures well unless they are treated as patients who have adrenal insufficiency.

The next panelist, Dr. William Franklin, Instructor in Medicine at Boston University School of Medicine, was then introduced.

Dr. Franklin listed the reactions to antibiotics as follows: 1. Allergic reactions: increased state of hypersensitivity, 2. Toxic or irritant reactions, and 3. Biological alterations by changes in bacteria and also changes in the patient.

Dr. Franklin said that antibiotics are so widely used at the present time that even food products

such as milk may contain them. Salk Vaccine has approximately 200 units of Penicillin per cc. It also contains a small amount of Streptomycin. Because of the wide use of antibiotic preparations more allergic actions are anticipated. Some side effects of antibiotics are as follows: *Allergic*: 1. rash; 2. urticaria; 3. serum disease; 4. anaphylaxis; 5. eosinophilia; 6. exfoliative dermatitis and 7. asthma. *Probably allergic*: 1. fever; 2. purpura; 3. Henoch's purpura; 4. agranulo-cytosis; 5. Loeffler's syndrome; 6. necrotizing arteritis. *Possibly allergic*: 1. leukopenia; 2. anemia; 3. hepatitis; 4. nephritis; 5. peripheral neuritis.

Dr. Weinstein was then introduced.

Dr. Weinstein emphasized the fact that antibiotics do things to the patient as well as to the infecting organism. These changes may be serious. Broad spectrum antibiotics produce a negative nitrogen balance as long as the patient is on the drug. Riboflavin is excreted in huge amounts during antibiotic therapy.

Organisms become resistant to antibiotic therapy with prolonged use. Super-infections may occur with antibiotic therapy.

The program was very well planned and a very active question and answer session followed.

Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

The Annual Meeting of the Washington County Medical Society was held on January 11, 1956 at Quonset Officers Club at the Naval Air Station.

The meeting was opened promptly at 1:00 P.M. by the President, Dr. S. J. Capalbo.

Mr. H. B. Gavin, Director of Public Relations and Safety of the AAA, was introduced and proceeded immediately to discuss the problem of modern traffic. Mr. Gavin pointed out that there was no easy answer to the problem of highway traffic accidents and deaths. Great progress has been made through teaching programs in schools. Chiefly through education a distinct drop in highway accidents in the school age group has been recorded after these education programs. It is the older age group which seems to have the most accidents. Even considerable trouble from adults and parents occurs through negligence. The attitude of the driver is of paramount importance. The personal factor has not kept pace with the growth of increased speed of modern cars and horsepower.

The answer to the whole problem very largely rests on the human element. Seven per cent of accidents are caused by the type of roads, 8% from mechanical defects of cars, and the remainder are caused by personal element. The younger age

concluded on next page

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group have been maligned completely out of proportion to their responsibility for accidents. Legislation concerning re-examination of drivers may possibly be pending.

Following Mr. Gavin's interesting discussion, a question period was held. Mr. J. F. Shea and Mr. B. H. Fitzpatrick of the Lederle Company gave some information concerning the proposed tour of the Lederle Company at Pearl River, New York.

Dr. Nestor introduced a motion regarding traffic injuries. The motion was seconded by Dr. Gongaware. The motion was placed in the form of a resolution and adopted.*

A committee consisting of Doctors Jones, DeWees, Nestor was appointed to work with this traffic resolution.

Minutes of the previous meeting were read and accepted as read, including the treasurer's report which was found to be in order, as audited by Dr. Potter.

Dr. Nathans' report on the Council stating that benefit funds for physicians (elderly) was purely on a voluntary basis.

OLD BUSINESS: Dr. Nathans commented concerning the pension plan for the Medical Library and Society employees.

Dr. Pinto's application for membership in the Society was again presented. Dr. Nathans made a motion that it be accepted. This was seconded and accepted by the meeting.

NEW BUSINESS: Yearly election of officers took place as follows:

President: Martin J. O'Brien, M.D.

First Vice President: Frederick C. Eckel, M.D.

Second Vice President: James A. McGrath, M.D.

Secretary-Treasurer: Elmer T. Gale, M.D.

Councillor: Samuel Nathans, M.D.

Alternate: Joseph L. C. Ruisi, M.D.

*(EDITOR'S NOTE: The complete resolution was presented to the House of Delegates and was published in the minutes of the house meeting in the March issue of the JOURNAL.)

RHODE ISLAND MEDICAL JOURNAL

Delegates: Thomas Nestor, M.D.; Hartford P. Gongaware, M.D., and James A. McGrath, M.D.

Censors: A. L. Manganaro, M.D.; Freeman B. Agnelli, M.D., and William H. Tully, Jr., M.D.

Upon motion duly made and seconded, it was voted to adjourn.

The following doctors were present at this meeting: Doctors Addario, Capalbo, Gale, Gongaware, Jones, Kraemer, Manganaro, Manning, McGrath, Nathans, Menzies, Nestor, O'Brien, Potter, Tatum, Tully, Walsh, DeWees. Guest: Dr. Alfred Gobeille.

MARTIN J. O'BRIEN, M.D.
Secretary-Treasurer

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was called to order at 8:05 p.m. on Wednesday, March 28, 1956, with Dr. Malone presiding and guests from the Newport Hospital House Staff and from the Miriam Hospital attending. The meeting was held at the Hotel Viking.

The minutes of the last meeting were read and approved. Dr. Brownell reported for the last meeting of the House of Delegates.

The following were elected to office:

Counselor: Samuel Adelson, M.D.

Delegates: Charles Serbst, M.D.; Henry Brownell, M.D.

Censors: Norman MacLeod, M.D.; Daniel Smith, M.D.

The speaker of the evening was Dr. Maurice D. Strauss, Chief of the Medical Service of the Boston Veteran's Hospital and Professor of Medicine at Boston University Medical School. He gave a highly informative and entertaining talk on *Acute Renal Failure*.

The meeting adjourned at 9:30 P.M.

Respectfully submitted,

DONALD B. FLETCHER, M.D., Secretary

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1. Riseman, J. E. F. and Brown, M. G. Arch. Int. Med. 60: 100, 1937

2. Brown, M. G. and Riseman, J. E. F. JAMA 109: 256, 1937.

3. Riseman, J. E. F. N. E. J. Med. 229: 670, 1943.

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From the Estate of H. G. Partridge, M.D., we received three hundred nineteen bound volumes and five pamphlets. These were checked and most of the titles added to our collection.

Manuscript Collection: Dr. Thomas Perry, Jr. presented the Library with a copy of his paper, "Ambroise Paré, Barber-Surgeon," which was delivered before the Review Club, May 10, 1956.

Rhode Island Medicine: Dr. Seebert J. Goldowsky gave us two copies of the reprint of his article "The Beginnings of Medical Education in Rhode Island."

Two new titles have been added to the Davenport Collection and are available for circulation: Charles F. Bove with Dana Lee Thomas—*A Paris Surgeon's Story*. Little, Brown & Co., Bost., 1956. Merrill Moore—*A Doctor's Book of Hours Including Some Dimensions of the Emotions*. Charles C Thomas, Springfield, Ill., 1955.

Mrs. Charles F. Gormly purchased the following volume for the Gormly Collection: Louis J. Regan—*Doctor and Patient and the Law*. 3rd ed. C. V. Mosby Co., St. L., 1956.

One book was purchased through the Donley Fund: The Founders of Neurology. One Hundred and Thirty-three Biographical Sketches. Prepared for the Fourth International Neurological Congress in Paris by Eighty-four Authors. Edited by Webb Haymaker, with the bibliographical and editorial assistance of Karl A. Baer. Charles C Thomas, Springfield, Ill., 1953.

Recent Day Fund purchases were:

Harry Beckman, editor—*Year Book of Drug Therapy*. 1955-1956 series. Year Book Publishers, Chic., 1956.

Council of Community Services—*Directory of Health, Welfare and Recreation Agencies in Rhode Island*. Prov., 1956.

Janet Doe & Mary Louise Marshall, editors—*Handbook of Medical Library Practice*. 2nd ed. American Library Association, Chic., 1956.

Jerome Glaser—*Allergy in Childhood*. Charles C Thomas, Springfield, Ill., 1956.

Chester S. Keefer & Samuel E. Leard—*Prolonged and Perplexing Fevers*. Little, Brown & Co., Bost., 1955.

Leon Schiff, editor—*Diseases of the Liver*. J. B. Lippincott Co., Phil., 1956.

John H. Talbott & R. Moleres Ferrandis—*Collagen Diseases*. Grune & Stratton, Inc., N.Y., 1956.

Review volumes from the Rhode Island Medical Journal were:

William Boyd—*Pathology for the Surgeon*. 7th ed. W. B. Saunders Co., Phil., 1955.

Hugh J. Campbell, James B. Liberman—*Physician's Federal Income Tax Guide*. Edited by Henry D. Shereff. 1956 edition. Channel Press, Inc., Great Neck, N.Y., 1955.

E. V. Cowdry—*Cancer Cells*. W. B. Saunders Co., Phil., 1955.

William S. Spector, editor—*Handbook of Toxicology*. Vol. I. *Acute Toxicities of Solids, Liquids and Gases to Laboratory Animals*. Prepared Under the Direction of the Committee on the Handbook of Biological Data. W. B. Saunders Co., Phil., 1956.

Dorothy and Philip Sterling—*Polio Pioneers. The Story of the Fight Against Polio*. Doubleday & Co., Inc., N.Y., 1955.

The following gifts were received:

Charles S. Cameron—*The Truth About Cancer*. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1956. Gift of Peter Pineo Chase, M.D.

Clinical Conference of the Chicago Medical Society, March 1, 2, 3, 4, 1955. Chic., 1956. Gift of the Chicago Medical Society.

Council on Medical Service, American Medical Association—*Voluntary Prepayment Medical Benefit Plans*. 10th ed. Chic., 1955. Gift of the Association.

Growth and Development of Dental and Skeletal Tissue. Clinical and Biological Aspects. Report of the Seventeenth Ross Research Conference. Gift of the Ross Laboratories, Columbus, Ohio.

Frank E. Holman—*Story of the "Bricker" Amendment (The First Phase)*. Committee for Constitutional Government. N.Y., 1954. Gift of the Executive Office.

Annual Report of the Charles H. Hood Dairy Foundation, 1955. Bost., n.d. Gift of the Foundation.

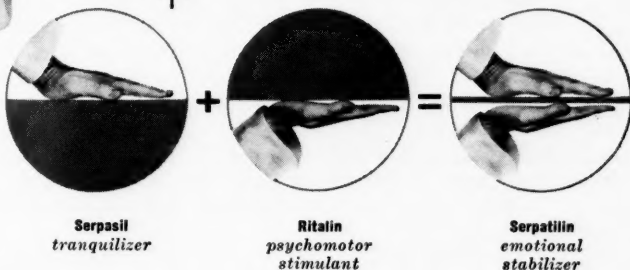
Index-Catalogue of the Library of the Surgeon General's Office. Vol. XI, Fourth Series. MH-MN. Wash., 1955. Gift of the Armed Forces Medical Library.

Jackson County (Mo.) Medical Society—*Medical*.

concluded on page 286



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1. Arnoff, B.: Personal communication. 2. Lazarte, J. A., and Petersen, M. C.: Personal communication.

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concluded from page 284

Health and Related Facilities, Kansas City Area. Including Pictorial Roster and Handbook. Kansas City, Mo., 1955-56. Gift of the Executive Office. James Jackson—Another Letter to a Young Physician: To Which Are Appended Some Other Medical Papers. Bost., 1861. Gift of Frank Merlino, M.D.

Esmond R. Long & Seymour Jablon—Tuberculosis in the Army of the United States in World War II. An Epidemiological Study with an Evaluation of X-ray Screening. VA Medical Monograph. Wash., 1955. Gift of the Veterans Administration.

Roger Lea MacBride—Treaties Versus the Constitution. The Constitution and Free Enterprise Foundation, Inc., N.Y., 1955. Gift of the Executive Office.

Poliomyelitis. Papers and Discussions Presented at the Third International Poliomyelitis Conference. Compiled and Edited for the International Poliomyelitis Congress. J. B. Lippincott Co., Phil., 1955. Gift of the Conference.

Thomas H. Sternberg & Victor D. Newcomer—Therapy of Fungus Diseases. An International Symposium. Little, Brown & Co., Bost., 1955. Gift of E. R. Squibb & Sons.

United States Department of Agriculture—Index-Catalogue of Medical and Veterinary Zoology. Supplement 5. Authors: A to Q. Wash., 1956. Gift of the U.S. Government.

Received through Exchange with the Universitetsbiblioteket, Lund:

Sven Bergman—In Vitro Studies on Antimycotics. Lund, 1955.

Rolf Blomstrand—Studies on Intestinal Fat Absorption. Lund, 1955.

Harald Brodin—Longitudinal Bone Growth. The Nutrition of the Epiphyseal Cartilages and the Local Blood Supply. Copenhagen, 1955.

Carl-Martin Fajers—On the Effect of Brief Unilateral Renal Ischemia. Lund, 1955.

Lars G. Hallen—Methods of Preservation and Fate of Homologous Arterial Grafts: An Experimental Study in Dogs. Stockholm, 1955.

Gunnar Hollunger—Guanidines and Oxidative Phosphorylations. Lund, 1955.

Anna-Brita Laurell—On Antibodies Separated by Paper Electrophoresis with Special Reference to the Wassermann Reagents. Lund, 1955.

Arne Norman—Studies on Conjugated Bile Acids. Lund, 1955.

Sture Rafstedt—Studies on Serum Lipids and Lipoproteins in Infancy and Childhood. Lund, 1955.

Jan Sjörrall—Studies on Bile Acid Metabolism. Lund, 1955.

RHODE ISLAND MEDICAL JOURNAL

Bertil Wedin—Embryonic Segmentations in the Head. Studies on the Development of the Vertebrate Head. Malmö, 1955.

BOOKS RECEIVED FOR REVIEW

The Editor acknowledges the receipt of the following books and thanks the publishers for sending them. Unfortunately, not every volume received is reviewed either because of lack of space or because the reviewer to whom the book is assigned fails us. Whether reviewed or not, the books are appreciated and are available at the Library.

PHYSICIAN'S FEDERAL INCOME TAX GUIDE. 1956 Edition by Hugh J. Campbell and James B. Liberman. Edited by Henry D. Shereff. Channel Press, Inc., Great Neck, N.Y., 1955. \$2.50.

"The improved tenth edition of a book used by well over half the practicing physicians in America."

THE EXCEPTIONAL CHILD FACES ADULTHOOD. Proceedings of the 1955 Spring Conference of the Child Research Clinic of the Woods Schools, held in New York City, May 6 and 7. Langhorne, Pa., 1955. \$1.00.

This is the fourth of a special series of conferences dealing with the problems of the exceptional child. Educators, parents, physicians, psychologists, social workers and vocational counselors participated in the discussions.

PRACTICAL FLUID THERAPY IN PEDIATRICS by Fontaine S. Hill. W. B. Saunders Company, Phil., 1954. \$6.00.

"The pathophysiology of all major types of fluid and electrolyte imbalance in infants and children is covered. Methods of treatment are specifically explained."

PRACTITIONER. Special Number on Advances in Treatment. vol. 175. No. 1048. October 1955. 7s. 6d.

Dr. Arthur M. Fishberg of New York and Dr. Franz J. Ingelfinger of Boston are included among the authors of these articles on recent therapies.

HANDBOOK OF TOXICOLOGY. Volume I—Acute Toxicities of Solids, Liquids and Gases to Laboratory Animals. Edited by William S. Spector. Prepared under the Direction of the Committee on the Handbook of Biological Data, Division of Biology and Agriculture, The National Academy of Sciences, the National Research Council. W. B. Saunders Company, Phil., 1956. \$7.00.

There are to be five volumes of this National Research Council sponsored work which will be the "most comprehensive collection of data ever compiled on the toxic qualities and dosages of all substances which have known adverse effects on living organisms."

FAR FROM ROUTINE

concluded from page 266

We have in this copy of the JOURNAL two papers dealing with matters which are far from routine. Of course, it is not a new departure to make a cineplastic amputation. Neither are such amputations very common. We feel that it is interesting to see just how Doctor Savastano went about this and his frank statement as to the results which he has achieved so far.

Amputees of course have to adapt themselves to a new way of life. They do not get along well in their early post-operative periods. They require a lot of practice, but a visit to the great amputation hospital at Roehampton, England years ago showed that they can develop wonderful agility.

Whether a cineplastic operation will help the average amputee to handle things better may be a question, but the aesthetic and the psychic undoubtedly plays a large part with them. In fact it is not uncommon for a person with an amputated arm to wear an artificial hand a good part of his time with which he can do practically nothing, having also a hook or pliers or such things with which he may do his work. If the cineplastic operation can combine these two properties of the aesthetic and the useful, it will be a great improvement.

Doctor Silver's paper treats a subject with which

very few of us are familiar. As we understand it, he is not advocating any very general rules of procedure, but he has recited two exceedingly interesting cases which it would seem were brilliant in their results. He frankly is giving us two brilliant examples of this work, but we believe is not laying down any general rules of procedure in convulsive cases. We must remember, however, that the remarkable heart surgery of the present day did not start off with brilliant results or certainly not with the brilliant results we expect nowadays, but those early cases certainly led up to something exceedingly worth while. We congratulate the writers of these two papers on giving us clear views of their problems, and giving us at least some hopes for much further progress in the future.

CORRECTION

In the published Annual Report of the Medical Milk Commission of the Providence Medical Association the name of Dr. John E. Farley was inadvertently omitted from the list of members of the Commission.

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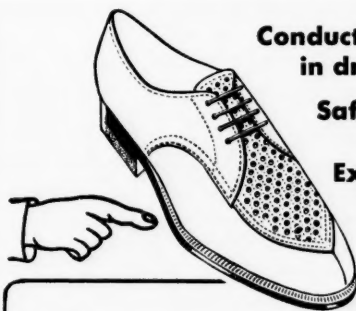
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BOOK REVIEWS

A MODERN PILGRIM'S PROGRESS FOR DIABETICS by Garfield G. Duncan, M.D. W. B. Saunders Co., Phil., 1956. \$2.50

This is a compact, well-printed book "primarily for those who have diabetes and their relatives, to give them a broader understanding of diabetes and to qualify them to be better able to follow the guidance of their family doctors."

The first section, in story form, follows a social service worker, herself a diabetic, as she goes about her work in and out of the hospital meeting different types of diabetic patients. Considered are the obese, brittle, juvenile, well and poorly controlled diabetic, insulin shock, diabetic coma, the use of types of insulin in usual and unusual situations and the effects of infection and neglect.

The second portion of the book is a well-written, point by point, "how to do it." It takes up such matters as just how to measure and give insulin, and how to sharpen needles; gives charts of weights and measures, food exchanges and practical recipes. There is also a glossary of medical terms.

In trying to make a good critical review of this book, I decided to take a small public opinion poll. Besides myself, a doctor-mother of a diabetic, I consulted 1) my son, a twenty-two-year-old college senior and a diabetic of ten years standing, 2) a former home economics teacher of thirty years ago, and 3) the wife of a diabetic.

The college senior thought it might be a bit confusing to a new diabetic to read about so many types of diabetes at once. He also thought that the write-up of the first part might be a bit juvenile. However, I think he read it with interest.

The former teacher thought it interesting and was glad to get a better understanding of why the treatment of each case of diabetes had to be individualized.

The wife of the diabetic also found it very interesting and instructive. She was the one who really looked over the glossary of terms first, looked at the appendix, liked the recipes and wanted to know where she could buy the book.

I consider her opinion the most valuable one of the group and hence feel that the book is not *just another book* on diabetes but would be a real help to diabetics and their families in understanding their disease.

AMY E. RUSSELL, M.D.

CURRENT THERAPY 1956. Edited by Howard F. Conn, M.D. W. B. Saunders Company, Phil., 1956. \$11.00

This book is a mammoth annual compendium of the "latest" in the therapeutic management of disease in general and of most diseases in particular. It is of large format, in clear print, supplied with an orderly table of contents, helpful chapter subdivisions, several appendices with roster of drugs, tables of metric and apothecaries' systems, and lastly an index of authors and of subjects. If some one subject has not been touched upon, it is that nothing newer has been added within a reasonable time and that it was described therapeutically in one of the preceding seven issues.

This tome is therefore the eighth in the edition of an annual series and in the author's preface, we find that "it is presented to the practicing physician." Two hundred and seven contributors and consultants representing a cross-section of medical thinking from the entire territorial U.S.A., authored the various articles. The editing of all this material represents no doubt an all-consuming task.

CURRENT THERAPY is chiefly for quick reference, very timely in 1956 as its title indicates. It is helpful in keeping abreast of the rising tide of new drugs and methods and is interesting also in its "polling of opinion" so to speak from a large number of authorities on the subjects treated. Certainly no more could be expected of one single encyclopedic volume.

JEANNETTE E. VIDAL, M.D.

PREVENTIVE MEDICINE IN WORLD WAR II, Volume III, Personal Health Measures and Immunization. Office of the Surgeon General, Department of the Army, Washington, D.C., U.S. Government Printing Office, 1955. \$3.25

This is the second of a group of volumes to be published as part of a clinical series of the History of the Medical Department of the United States Army during World War II. It is a rather detailed history of the preventive aspects of the personal health and immunization procedures that were followed during the late World War.

The whole presentation is orderly and well done and of more interest than the usual government publication.

concluded on page 290



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BOOK REVIEWS

concluded from page 288

The chapters on Nutrition, Preventive Psychiatry and the Army Immunization program were particularly well done. It was unfortunate that the epidemiological approach to preventive psychiatry was not instituted earlier in the preventive psychiatric program. The arrangement of the chapter on immunization, listing the various procedures under identical headings, was excellent.

The summary and conclusions at the end of several of the chapters were particularly helpful, as were the various charts and tables.

The book will be of interest to students of medical history and others interested in preventive medicine.

RAYMOND F. McATEER, M.D.

MANAGEMENT OF ADDICTION. Edited by Edward Podolsky, M.D. Philosophical Library, N.Y., 1955. \$6.00

MANAGEMENT OF ADDICTION, edited by Edward Podolsky, M.D., and published by Philosophical Press, consists of a series of papers said to have

RHODE ISLAND MEDICAL JOURNAL

been previously published on the management and treatment of alcoholic and drug addiction.

The book is divided into two parts, the first consists of twenty-six papers dealing with alcoholic addiction, its causes, management and treatment. Such causes as sociological, endocrinological, psychiatric and nutritional are discussed. These are followed by procedures for treatment, some of which are highly specialized and not easily applied, while others are more applicable. Of special interest are the chapters on geneto-trophic approach to the understanding and management of alcoholism.

The second half of the volume follows much the same outline—dealing with addiction to drugs other than alcohol.

Although there is much to be desired and probably little that can be applied by the general practitioner, the book makes a contribution in that it brings under one cover a multi-dimensional approach to a vexing problem. Its perusal may give insight into, and even stimulate interest in, a subject that all too often is passed off either too lightly or as too troublesome.

DAVID J. FISH, M.D.



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